PERSONAL ACCIDENT AND/OR SICKNESS CLAIM FORM

We are pleased to enclose a claim form as requested.

Most delays in settling claims arise because claim forms are not fully completed or requested documents are not sent to us. We would therefore ask you to answer all questions fully and ensure all requested documentation is returned together with this form as soon as possible.

IMPORTANT :

Please remember to read and sign the declaration, failure to sign the declaration will delay the assessment of your claim.

The Doctor's Medical Report must be completed and Medical certificates submitted fortnightly so long as disablement continues.

Before having the Doctors Medical Report completed please read and sign the Medical Report consent form.

If you find you do not have sufficient room to answer any question in full or you think you have additional information you feel is pertinent to your claim please use additional paper remembering to sign and date each sheet. Please indicate the number of additional pages attached to the claim form below the declaration.

Please return the completed form to your Insurance Broker or the office detailed below.

Naturesave Policies Ltd
58 Fore Street
Totnes
Devon
TQ9 5RU

mail@naturesave.co.uk

Thank you for your co-operation.

PERSONAL ACCIDENT AND SICKNESS CLAIM FORM

The issue of this form does not imply admission of liability
If unable to apply personally this form may be filled up on behalf of the claimant.

Certificate No.	Certificate Period:	to	Sum Insured :
Name of insured :			
Name of claimant :		Date of Birth :	
Address of Claimant :		Telephone No :	
Occupation :		Fax No	
Gross Annual Salary :		Email Address :	

1. **DETAILS OF ACCIDENT/SICKNESS**	
(a) Date of accident/appearance of symptoms. (b) Description of injury/sickness. (c) In case of accident, please describe how happened.	(a) (b) (c)
2. **PERIOD OF ACCIDENT/SICKNESS**	
(a) Due solely to above mentioned accident/illness have you been unable to attend to any part of your business or occupation?	(a) Yes / No
(b) If answer to 2(a) is "yes" state:- (i) Are you still disabled? (ii) Dates between which you have been continuously disabled	(b) (i)Yes / No (ii) **From the** **Both days** **To the** **Inclusive**
(c) If you have been able to attend to any part of your business or occupation since the accident/illness please give particulars including dates.	(c)
3. **PREVIOUS HISTORY**	
Have you any previous history of a similar injury? If so give full details.	
4. **MEDICAL EXPENSES**	
If you have coverage for medical expenses as a result of the above please supply full details of the expenses incurred together with bills and receipts.	
5. OTHER INSURANCES	
(a) Have you any other insurances under which this claim or part thereof may be recoverabl ?	(a) Yes / No
(b) If the answer to 5(a) is "yes" please supply details of Insurer and coverage.	(b)
6. MEDICAL PRACTITIONER	
Please supply the name and address of your usual Medical attendant.	Name: Address:

DECLARATION

I understand that the making of a fraudulent claim by providing information which is untrue is a criminal offence likely to lead to prosecution. I confirm that the information given on this form and information provided by myself on pages attached to this form is, to the best of my knowledge and belief, true in every respect and that the amounts claimed have not been refunded to me or claimed from any other source.

Signature : _____

Full Name : _____

Date : _____

YOU MUST READ THE DECLARATION BEFORE SIGNING.
PLEASE READ AND SIGN THE ACCESS TO MEDICAL RECORDS CONSENT FORM OVERLEAF.

Please use additional paper if space provided on this form is insufficient, please attach additional paper when submitting this form.

Number of additional pages attached :

MEDICAL REPORT

Claimant details:

Name of Claimant _____

Name of Patient if different from Claimant _____Patients Date of Birth_____

Relationship to Claimant_____

Dear Doctor,

The above named person has submitted a claim under their Personal Accident / Sickness Insurance Policy. In order for us to assess the claim we would be grateful if you would answer the questions below. Please use additional paper if required and indicate the number of pages used below the declaration.

Name of person to whom this report refers (the patient) _____

Are you the patient's usual practitioner? YES / NO

How long have you acted in this capacity?_____ Years.

What is the precise nature of the condition, illness or injury that has caused a claim to be made under this policy?

_____

When were you first consulted about this condition? _____

Has the patient suffered from the same or a similar condition in the past? YES / NO

If so please advise dates of all previous treatments _____

Has the patient been included on a waiting list for in-patient treatment for this condition? YES / NO

If so please advise the date they were put on the list _____

Is the patient suffering from any other condition which may affect the normal process of recovery? YES / NO

If so please give details :_____

If the patient is not in full time employment please replace the word 'occupation' with 'usual day to day activities' where it appears in the following questions, and indicate here : The patient informs me he/she is / is not in full time employment

Has the patient been TOTALLY disabled from attending to ANY part of his/her business or occupation? YES / NO

If so please give date of commencement of TOTAL disablement :_____

When did or when do you expect the claimant to return to his/her occupation :

i)on a partial basis :_____

ii) on a full time basis :_____

DECLARATION

I have examined the patient and/or his medical records. I confirm that to the best of my knowledge the information given above is correct and that no details relevant to the case have been omitted.

Signed

Name

Qualification

Practice stamp:

Date of signing:

Number of additional pages attached :

MEDICAL REPORT CONSENT FORM

Name: …… Date of Birth: ……/……/……

Address: ……
……
……
……

General Practitioner: …… Specialist: ……

Address: …… Address: ……
…… ……
…… ……
…… ……

Telephone: …… Telephone:……

I hereby consent to a medical report or my records being supplied in confidence to the Insurers' Medical Adviser by the above named doctor or their nominated deputy. I understand that it may be necessary to discuss some of these matters in the strictest confidence with their personnel in order to process the claim underwriting decision.

I understand my rights under the Access to Medical Reports act 1988 and have read the summary of my principal rights under this act.

- I DO NOT wish to have access to the medical report or noted before they are supplied.
- I DO wish to have access to the medical report or notes before they are supplied and understand that I have 21 days in which to make the necessary arrangements with my medical practitioner, who is entitled to charge a fee for this service.
- I agree to be seen and examined by the Insurers Medical Adviser. I also understand that any information or opinions drawn from his examination of me may also be divulged to the Insurers (or agreed third parties) and also understand that this may be used in making underwriting and claims decisions.

Delete where inapplicable

A copy of this consent shall be valid as the original.

Signed: …… Date: ……/……/……

ACCESS TO MEDICAL REPORTS 1988

This is a summary of your principal rights under Act, which is concerned with reports provided for employment or insurance purposes by a medical practitioner who is, or has been, responsible for your care.

Option A. You may withhold your consent for the report from a medical practitioner.

Option B. You may consent to the application but indicate your wish to see the report before it is supplied. (You must make the necessary arrangements with the medical practitioner to see the report. It will not be sent to you automatically).

The medical practitioner will be informed that you wish to have access to the report and will allow 21 days for you to see and approve it before it is supplied to the applicant. If the medical practitioner has not heard from you in writing within 21 days of the application for the report being made, he/she will assume that you do not wish to see the report and that you consent to its being supplied.

When you see the report, if there is anything in it which you consider incorrect or misleading, you can request (but this request must be in writing) that the medical practitioner amend the report, but he/she is not obliged to do so. If the medical practitioner refuses to amend it, you may :

i) withdraw consent for the report to be issued.

ii) ask the medical practitioner to attach to the report a statement setting out you own views.

iii) agree to the report being unchanged.

NOTE: The medical practitioner is not obliged to show you any parts of the report which he/she believes might cause serious harm to your physical or mental health or that of others, or which would reveal information about a third party or the identity of a third party who has supplied the practitioner with information about your health, unless the third party also consents. In those circumstances the medical practitioner will so inform you and your access to the report will be appropriately limited.

Option C. You may consent to the application for the report, but indicate that you do not wish to see the report before it is supplied. Should you change your mind after the application is made, and notify the medical practitioner in writing, he/she should be allowed 21 days to elapse after such notification so that you may arrange to have access to the report (if the report has not already been supplied before you change your mind).

Option D. Whether or not you do decide to seek access to the report before it is supplied, you have the right to seek access to it from the medical practitioner at any time up to six months after it was supplied.

Please note that where a copy of the medical report is supplied to you, the practitioner may charge a reasonable fee to cover the cost of supplying it.