ACCIDENT & HEALTH CLAIMS

7-8 Ducketts Wharf, South Street, Bishop's Stortford, Hertfordshire, CM23 3AR
Telephone: 01279 713860 Fax: 01279 467138

PERSONAL ACCIDENT/ILLNESS Claim Form

Please return your completed Claim Form to the above address or via email to claims@ahclaimsservices.com
Please note we aim to respond within 5 working days of receipt.
The below information should allow us to assess your claim in accordance with the terms and conditions of your Insurance. However, depending on the documentation provided, additional information may be required.

Claim Form Checklist

1.	The Claim Form has been completed in its entirety.	Yes, completed ☐			
2.	You have attached a copy of the Schedule of Insurance if one has been issued to you.	Yes, attached ☐		Not applicable ☐	
3.	You **must** provide all sick notes you have been issued to date.	Yes, attached ☐			
4.	We require any hospital admission and discharge forms.	Yes, attached ☐		Not applicable ☐	
5.	We require any letters or reports from your GP/usual treating doctor and/or specialist/consultant.	Yes, attached ☐		Not applicable ☐	
6a.	For PAYE employees receiving an annual salary, we require your most up to date contract of employment (and any appropriate addendum confirming your salary at the date of disablement). For PAYE employees not receiving an annual salary, we require wage slips applicable to the 13 weeks immediately prior to the injury/illness.	Yes, attached ☐		Not applicable ☐	
6b.	For self-employed persons, we require your latest final personal tax return alongside bank statements for the 2 months immediately prior to the date of your accident/illness.	Yes, attached ☐		Not applicable ☐	

If you are self-employed and wish for us to consider your fixed contracted business costs as part of your Net Weekly Wage, please provide copies of the contracts for these costs.

7.	You have completed, signed and dated the Access to Medical Reports consent (page 5) of the Claim Form.	Yes, completed ☐	
8.	Your doctor has fully completed pages 6 and 7 of the Claim Form and included their stamp.	Yes, completed ☐	
9.	You have signed page 8 of the Claim Form.	Yes, completed ☐	
10.	You have taken photocopies of all documents.	Yes, completed ☐	

Please feel free to contact us on +44 (0) 1279 713860 or claims@ahclaimsservices.com or your agent, to discuss any section of the claim form or if you feel this claim form is not suitable for the circumstances of your claim.

Personal Accident/Illness Claim Form

Insurance Details

Certificate Number:

Name of Certificate Holder:

Purchased Through (broker / agent):

When did you originally purchase / join this Insurance: dd/mm/yy

Personal details of all people claiming

Title	Full Legal First Name	Full Legal Surname	Date of Birth	Occupation*	Nationality	Usual Country of Domicile

*Description of Your Usual Duties:
Continue on a separate sheet if necessary

Country of Post (if applicable):

Contact Details

Claimant's full address:

Postcode and Country:

Daytime telephone:

Email address:

Wherever possible we will try and communicate with you by email or telephone for a quicker service

Please indicate your reason for claiming: Accident ☐ Illness ☐

Date and time of the accident or onset of illness: dd/mm/yy HH:MM

Date you stopped performing your normal occupation: dd/mm/yy

Are you still incapacitated as a result of your accident or illness? Y/N

If no, please confirm the date you returned to work: dd/mm/yy

Have you returned to work in the same capacity as before your accident or illness? Y/N

If no, please confirm the hours worked and the duties performed:
Continue on a separate sheet if necessary

Are you medically signed off as unfit to work? Y/N
If yes, please attach a copy of all sick notes to the Claim Form

Please provide full details of where and how the accident occurred:

Alternatively, if this relates to an illness, please provide full details of the circumstances surrounding your illness and when you first noticed symptoms:

Continue on a separate sheet if necessary

If the accident was as a result of criminal assault or a road traffic accident, please confirm the name and address of the police station dealing with the case and the incident report number, and please provide full details of any witness(es) (if applicable):

Have you ever suffered from this or any associated disability, prior to this Insurance commencing?

If yes, please provide full details including dates:

Please provide the full name and address of every doctor consulted for the present injury or illness also including the details of your GP/usual treating doctor:

When did you first seek medical treatment for your accident or illness?	dd/mm/yy HH:MM
Were you admitted to hospital as a result of your accident or illness?	Y/N
If yes, please confirm the dates of admission and discharge **and provide a copy of the hospital forms**:	dd/mm/yy — dd/mm/yy
What is your expected date of return to work?	dd/mm/yy
Have you previously claimed benefits under this Insurance?	Y/N

If yes, please provide full details:

Are you covered for benefits for your accident or illness under any other Insurance?	Y/N

If yes, please provide full details:

Please confirm your employment status:	Employed	☐	Self-Employed	☐	Unemployed ☐

Company name:	
Company address:	
Company contact name and contact details: Include email address and telephone number	
Please state your **gross** average weekly wage, calculated over the 12 months prior to the commencement of your accident or illness:	

For Employed Persons (Salaried):
Please provide evidence of your annual salary prior to the commencement of your accident or illness. Your most recent contract of employment (and any applicable up to date salary addendum) is acceptable evidence.

For Employed Persons (Non-salaried):
Please provide evidence of your earnings for the 13 weeks prior to the commencement of your accident or illness. Wage slips are acceptable evidence.

For Self-Employed Persons:
Please provide your latest final personal tax return, and bank statements for the 2 months immediately prior to the date of your accident or illness. If you are claiming your fixed contracted business costs as part of your Net Weekly Wage, please provide copies of the contracts for these costs.

If your claim is agreed how would you like to be paid?

- Please note payment directly into your bank account will be quicker than sending a cheque.
- For payments into non UK bank accounts we can only arrange payment into the final receiving bank and not through an intermediary.

Preferred Payment Method		Bank Details	
Cheque (UK bank accounts only)	☐	Confirm payee:	
BACS (UK bank accounts only)	☐		
		Name of account holder:	
		Name of bank:	
		Account number:	
		Sort code:	
		Type of account: Advantage, Gold, Platinum etc	
Wire Transfer (Payments into non UK bank accounts)	☐		
		Name of account holder:	
		Account holders address:	
		Name of bank:	
		Bank address: Including country	
		Bank swift code /BIC: For payments to all countries	
		Bank IBAN: For payments to all European countries	
		Account number:	
		Routing number: For payments to the USA	
		BSB code: For payments to Australia	
		Currency of this account:	

Declaration to be completed by the Claimant

Access to Medical Records Act 1988/Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (made under the Northern Ireland Act 1974) and the Data Protection Act 1998.

To enable Accident & Health Claims Services LLP to assess your claim, it may be necessary to obtain medical evidence. Any reports which are requested from your doctors are subject to Acts. Please note that reports requested from doctors appointed by Accident & Health Claims Services LLP are not subject to the Acts.

In summary your statutory rights are as follows;

- A Medical Report cannot be requested from any doctor who has attended you without your written authority.
- You do not have to give your consent. If you do consent, you can say whether you wish to see the report before it is supplied. **If you do not give consent, we will not be able to proceed with your claim.**
- If you indicate below that you wish to see the report, you will then have 21 days from the date of notification to contact the doctor to make arrangements to see the report.
- The medical practitioner will be sent a copy of this declaration and where you have indicated you do wish to see a copy of the report, they will allow 21 days from the date of notification for you to see and approve it before it is supplied to us. 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 it being supplied.
- If you indicate that you do not wish to see the report, we do not have to notify you before we apply for one.
- If you indicate below that you do not wish to see the report before it is sent to us, you may ask the doctor to show you a copy of the report for up to 6 months after it has been supplied. The practitioner may charge you a reasonable fee for the cost of supplying the report to you.
- If you see the report before it is sent to us, the doctor cannot submit it until you give your consent. You can write to the doctor, asking that any part of the report which you consider to be incorrect or misleading be amended and to have attached to the report a statement of your views on any part where you and the doctor are not in agreement.
- The doctor is not obliged to let you see any part of a report if,
    1. In his/her opinion it would be likely to cause serious harm to your physical or mental health, or that of others.
    2. It would indicate the doctor's intentions towards you.
    3. Disclosure would be likely to reveal information relating to, or the identity of, someone else that has supplied information about you, unless that person has consented.

I hereby authorise any physician or other person who has attended or examined me to furnish Accident & Health Claims Services LLP or its authorised representative with any and all information with respect to any illness, sickness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records ("**Medical Information**").

I do ☐ do not ☐ wish to see a copy of the medical report before it is sent to Accident & Health Claims Services LLP (**please tick**)

Further, I hereby recognise that in circumstances whereby I have been previously treated by a doctor internationally, local laws may prevent Accident & Health Claims Services LLP or its authorised representative from directly obtaining Medical Information from the doctor(s) concerned. If this is the case, I hereby agree to obtain such Medical Information directly from the doctor(s) concerned, for onwards transmission to Accident & Health Claims Services LLP or to its authorised representative.

A photocopy of this authorisation shall be considered as effective and valid as the original.

Claimant Name	Claimant Signature	Date Signed
		dd/mm/yy

Medical Certificate – to be completed by the patient's GP/usual treating doctor who must be duly qualified and registered. Please note that any charge made for the completion of this medical certificate is the responsibility of the claimant and is not refundable under the insurance cover.

Full name of the patient: | Date of Birth: dd/mm/yy

Are you the above patient's GP/ usual treating doctor? Y/N | If yes, for how long?

If not, please state your relationship?

Do you consider this claim to be as a result of: an accident Y/N or an illness Y/N

Please confirm the exact nature of the accident or illness sustained, together with prognosis:

Please confirm when the patient first sought advice regarding the accident or illness in question: dd/mm/yy

Has the patient suffered from this, or any associated medical condition within the last 24 months prior to this period of disablement? Y/N

If yes, please provide full details including dates:

At the time of the accident or commencement of the illness was the patient suffering from any other illness, disability or degenerative condition or disease? Y/N

If yes, please provide full details and whether the medical condition is affecting their recovery?

Is the disability due to Human Immunodeficiency Virus (HIV) and/or any HIV related sickness, any psychiatric, mental or nervous disorder, mental sickness, anxiety, stress or depression, self-inflicted injury, drug abuse, alcohol abuse, sexually transmitted disease, pregnancy or childbirth related conditions? Y/N

If yes, please provide details:

When do you expect the patient to be able to return to work? dd/mm/yy

Will the patient be able to return to full duties on the above date? Y/N

If no, please confirm the extent of duties the patient will be able to perform and the number of hours the patient will be able to work per day:

Doctor's Declaration

I confirm that the patient named above is/was under medical attention, and was totally prevented from working for remuneration or profit from his/her normal occupation **From** dd/mm/yy **To** dd/mm/yy

Doctor's Name (please print) Date dd/mm/yy

Doctor's Qualifications

Doctor's Signature

Official Surgery Stamp*

***** Please note this form will be returned if the Surgery stamp is omitted.

Data Protection

We will not discuss your claim with anyone else without your permission (including your spouse, relative, friend or legal advisor) unless you have provided their name below. For security we will ask them to verify their identity by confirming your date of birth, post code and claim number.

Name	Relationship

We may share information about you, including but not limited to Medical Reports, Private Investigators' Reports and Rehabilitation Coordinators' Reports where appropriate including:

- Your employer or your employer's nominated intermediary.
- Your nominated GP/usual treating doctor.
- Third Parties – including but not limited to your employer (where such employer is named as an Assured in the Schedule of the Insurance), underwriters, reinsurers, subcontractors, agents (including your/the insurance broker), Trustees in Bankruptcy and medical agencies (in the UK and abroad).
- Insurance reference agencies – this information will be used by other agency users in assessing insurance risk and fraud prevention.
- Government Regulators and the Ombudsman.
- Other Insurance Companies who require the information for lawful purposes.

You are entitled, without excessive delay, to access your information and to rectify any inaccuracies at any time by writing to us. We may charge a fee for supplying you with your information.

Declaration and Consents

1. I declare that all statements I have made are true and complete. I consent to Accident & Health Claims Services LLP or their agents undertaking any enquiries they consider necessary concerning the admission and continuation of the claim.
2. I have read and understood my statutory rights under the Access to Medical Records Act 1988/Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (made under the Northern Ireland Act 1974) as outlined above and I consent Accident & Health Claims Services LLP or their agents seeking medical information, including copies of my medical records, from any doctor who at any time has attended me, concerning anything which affects my physical or mental health.
3. I have read and understood the section on Data Protection Act 1998 and
    - I consent explicitly to Accident & Health Claims Services LLP or their agents being provided with confidential information, concerning the application for this insurance, including but not limited to sensitive information concerning my physical and/or mental health or condition from any third party.
    - I authorise the release of confidential information, including but not limited to sensitive personal data concerning my physical and/or mental health or condition obtained by Accident & Health Claims Services LLP or their agents, to my doctors or any doctors or specialists appointed by Accident & Health Claims Services LLP or their agents in relation to the claim and to the third parties referred to above beneath the heading 'Data Protection' who requires such information for lawful purposes.

Signature:		Date:	dd/mm/yy
Full Name			