CHUBB

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Claim form - Accident and Illness

This document contains fillable form fields.
It is recommended you **download** the file to fill in your information.

Data protection

We use personal information which you supply to us [or, where applicable, to your insurance broker] for underwriting, policy administration, claims management and other insurance purposes, as further described in our Master Privacy Policy, available here: https://www2.chubb.com/ie-en/footer/privacy-policy.aspx or by searching 'Master Privacy Policy' on https://www2.chubb.com/ie-en/. You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at dataprotectionoffice.europe@chubb.com.

Before completing this claim form you may prefer to submit your claim online, 24 hours a day, 7 days a week. It's easy to use and provides a contemporary claims experience for all customers www.chubbclaims.ie

Please write in black ink and use block capital letters.

- All relevant sections must be completed or marked 'not applicable'.
- Complete the checklist and ensure that you sign the declaration at the end of this form.

Name of Policyholder:

Certificate/Policy Number:

Insured details

Insured Person forename(s) (Mr/Mrs/Miss/Ms):

Insured Person surname:☐

Full address:

Daytime Telephone Number:

Evening Telephone Number:

Postcode:

Date of birth:

Email Address:

1. Claim details

Did you suffer an injury or an illness? ☐ Injury ☐ Illness

Please give date, time and place where injured or taken ill:

Date / time:

Place:

Have you suffered from this injury/illness in the past? ☐ Yes ☐ No If 'Yes' please give details (including dates and any treatment):

Do you consider anyone to blame for the injury or illness? ☐ Yes ☐ No If 'Yes' please provide details:

Name of Insurer/Company/ Individual	Address/Contact Details	Any Reference Numbers

If you were injured, please state:

How the injury occurred:

The injuries sustained (please include details of any broken bones):

If you were ill, please state:

Full details of the illness:

2. Employment Details

What is your occupation?

As a result of the illness/injury, did you miss time at work?
☐ Yes ☐ No

If No, please proceed to section 3 Hospital Statement

Name, address and telephone number of Employer:

Please describe the duties that you perform in your usual occupation:

Please provide your period of employment:
From:

To:

The date you ceased working?

Have you returned to work? ☐ Yes ☐ No

If Yes, please confirm the date you returned to work:

If you have not returned to work, on which date do you hope to do so?

3. Hospital statement

Were you hospitalised as a result of your injury/illness? ☐ Yes ☐ No

If No, please proceed to section 4 Doctor's Statement

This section must be fully completed by hospital medical staff or records department – any fee for completion of this section is the responsibility of the insured person:

Type of hospital/ward:

Name of Doctor or Consultant in charge:

The dates admitted and released:
Admitted:

Released:

Was any period spent in intensive care: ☐ Yes ☐ No

From:

To:

Was any surgery required: ☐ Yes ☐ No

If Yes, please provide a description of the surgery :

Was the patient subsequently confined to their home on medical grounds? ☐ Yes ☐ No

If Yes, please gives dates:
From:

To:

Is there any additional information that you feel is relevant?

Signed:

Dated:

Position held in Hospital:

Qualifications:

Please use validation stamp or complete in block capitals:

Hospital Name:

Address:

Telephone No:

Validation stamp:

Thank you for your assistance in completing this form.

4. Doctor's statement

This section must be fully completed by your own doctor or doctor providing outpatient treatment' - any fee for completion of this section is the responsibility of the Insured Person.

Patient's Name: (Mr, Mrs, Miss, Ms)

Date of Birth:

Please give full details of injury/illness:

Final diagnosis: :

If you have fully completed these sections and require to add more detail, please continue on a separate piece of paper and attach to your claim form, providing your name and certificate/policy number.

Has the patient ever suffered with this or any similar condition before the present episode?

☐ Yes ☐ No

When did the patient first receive medical attention for this condition?

If yes, please give details including dates treatment and consultation

Are you the patient's usual Doctor:

☐ Yes ☐ No

If NO please give name and address of usual Doctor:

On what date did incapacity commence?

Is patient still incapacitated?

☐ Yes ☐ No

If YES when will patient be able to return to work?

Was the patient hospitalised as a result of this condition?

If NO when did incapacity cease?

Is there any additional information that you feel is relevant?

Signed:

Dated:

Position held in Hospital:

Qualifications:

Please use validation stamp or complete in block capitals:

Hospital Name:

Address:

Validation stamp:

Telephone No:

Thank you for your assistance in completing this form.

Payee's bank details

If we approve your claim, we can credit the money direct to your bank account. This method is quicker, safer and more reliable than payment by cheque. If you would like us to do this, please complete the following:

Name of your Bank/Building Society

Address

IBAN

BIC

Account Number

Name of Account Holder(s)

Declaration

I declare that all the information given is to the best of my knowledge and belief, full true and correct. I give permission for any Medical Practitioner, Law Enforcement Agency or Statutory/Regulatory Authority mentioned with respect to this claim, to release information regarding my records..

Signed:

Date:

Checklist (reminder to provide, if applicable to your claim)

- ☐ Medical certificates
- ☐ Medical reports
- ☐ Hospital admission/discharge documents

Depending on your policy benefits, we may also ask for proof of income such as payslips, Tax Returns or audited accounts.

Please return the completed claim form together with any enclosures to your Insurance Broker or Chubb and please ensure:

- ☐ You have completed all relevant questions on this claim form
- ☐ You have enclosed all requested original documents (we recommend you retain copies)
- ☐ You have signed this claim form

Thank you for fully completing this claim form and enclosing all supporting documentation.

Chubb. Insured.℠