CHUBB

Claim Form
Personal Accident / Sickness

Chubb European Group Limited
Claims Department
PO Box 682
Winchester
SO23 5AG
T: 0345 841 0059
F: 0141 285 2901
uk.claims@chubb.com

Please write in black ink and use block capital letters.
All 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 no.
Insured Person forename(s) (Mr/Mrs/Miss/Ms)	Insured Person surname

Full address

	Postcode	Date of birth
Telephone no. business	Telephone no. home	

E-mail address

Employment Details

What is your occupation? _____

Please describe your duties _____

_____

_____

_____

_____

Name & Address of Employer _____

_____

_____

E-mail address of Employer

Please state average annual gross and net salary over previous 12 months from the date of the incident (please enclose copies of 13 weeks payslips prior to the event) or over the previous 36 months from the date of accident if self-employed (please provide evidence of income by means of Inland Revenue Tax Assessment forms or audited accounts):

GROSS _____ NET _____

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Accident/Sickness Details

Please give exact date and time when injured or taken ill: DATE_____TIME_____am / pm

Please state:-

(a) The date you ceased working: _____

(b) The date you returned to work: _____

(c) If you have not returned to work, on which date do you hope to do so?_____

If accident please state fully:-

(a) Where the accident occurred:_____

(b) How the accident occurred: _____

(c) The injuries sustained: _____

If illness please state full details of your illness _____

Have you ever suffered from this illness before? YES / NO

If YES please give details _____

Have you previously claimed under this or a similar policy? YES / NO

If YES please give details _____

Please give the name, address and policy number of any other insurance that may cover this injury _____

Hospital Statement only to be completed if claiming hospitalisation benefit

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

(a) Type of hospital/ward:_____

(b) Name of Doctor or Consultant in charge: _____

(c) The dates admitted and released:_____

ADMITTED:_____RELEASED:_____

(d) Was any period spent in intensive care: YES / NO

FROM:_____TO:_____

(e) Was the patient subsequently confined to their home on medical grounds? YES / NO

If YES, please give dates: FROM: _____TO: _____

Is there any additional information that you feel is relevant?

SIGNED DATE

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.

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Doctor's Statement

This section must be fully completed by attending doctor – any fee for completion of this section is the responsibility of the Insured Person

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

Date of Birth:_____ Height: _____Weight: _____

Please give full details of injury/illness: _____

_____

Final diagnosis: _____

_____

_____

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

Has the patient ever suffered with this or any similar condition before the present episode? YES / NO

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? _____

If NO when did incapacity cease? _____

Was the patient hospitalised as a result of this condition? YES / NO

Is there any additional information that you feel is relevant? _____

_____

_____ _____

SIGNED DATE

Please use validation stamp or complete in block capitals:-

Name: _____

Address: _____

_____

_____

Telephone No: _____

VALIDATION STAMP

Thank you for your assistance in completing this form.

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Access To Medical Reports Act 1988

Before your attending doctor can give a medical report on this claim form which is a requirement of this claim, you must give your consent. Before giving your consent, you should be aware of your rights under the act which are summarised as follows:-

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of this report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the Doctor to amend any part of the report which you consider to be incorrect or misleading. If the Doctor does not agree with your request you may attach your comments to the report.

NB: The Doctor may withhold all or part of the report from you if he considers that you may be physically or mentally harmed by it.

PATIENT DECLARATION
Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my claim

1. I hereby consent to Chubb seeking medical information from any Doctor who at any time has attended me concerning conditions which affect my physical or mental health.
2. ☐ I DO wish to see the report before it is sent to Chubb

   ☐ I DO NOT wish to see the report before it is sent to Chubb
3. I authorise such Doctor to disclose such information to Chubb.
4. I agree that a copy of this consent shall have the validity of the original.

SIGNED

DATE

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Payee's Bank Details

When the claim has been approved you may have the payment credited direct to your bank account. This payment method is both speedier and safer than by cheque. if you would like to take advantage of this arrangement then please complete the following:-

Name of your Bank/Building Society: _____

_____ Bank

Address _____

_____

_____

_____ Postcode _____

Bank Sort Code (from the top right hand corner of your cheque)

Account Number _____

Account Name(s) _____

Data Protection

The information that you and your medical representative have provided in the claim form and Doctor's Statement is 'sensitive data' as defined by the Data Protection Act 1998. Sensitive data includes any information about your physical and mental health. We require your consent before we can process this or any other such sensitive data that you may have already provided us with or may do so in the future.

In order to administer your claim, this information will be used by Chubb European Group Limited and its group companies. It may be held on computer and or in manual files for administration, and risk assessment purposes. We may disclose your personal data and sensitive data to, and may request information from other insurance companies for underwriting, claims handling and fraud prevention purposes.

By returning this form, you consent to our processing your sensitive personal data for the above purposes. You also consent to our transferring your information to countries which do not provide the same level of data protection as the UK, if necessary for the above purposes. If we do make such a transfer we will, if appropriate put a contract in place to ensure your information is protected. Where you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

Declaration

I declare that all the information given is to the best of my knowledge and belief, full true and correct.

SIGNED _____ DATE _____

Checklist

Please return the completed claim form together with any enclosures to your insurance broker or to Chubb European Group Limited and please ensure...

- ☐ You fully complete every question before your doctor completes his statement
- ☐ You have enclosed all requested original documents (we recommend you retain copies)
- ☐ You have signed this claim form
- ☐ Your attending doctor fully completes the statement

As failure to do so will result in delay in handling your claim

Thank you for fully completing this claim form.

Chubb. Insured.℠