UK Sickness claim form

Please make sure...

1. That you complete **all the relevant sections** and **sign** the claim form.
2. That you carefully read, then **sign and date**, sections **6.2** and **6.3** (Access to Medical Reports and Statement of truth). Please check that your dates are accurate, as we assess your claim against this information. In section **6.4** (claims payment), don't forget to write the last 4 digits of the account you would prefer to be credited
3. That your doctor fully **completes and signs section B**.
4. If you have been admitted as an inpatient to a ward, enclose your hospital admission/discharge summary sheet(s).
5. When you have completed all of the above, return the claim form and any additional sheets in the pre-addressed envelope. If you use your own envelope, please send it to the address below.
6. That you read and retain your claim Guidance Notes.

Important: You will not be issued with a claim number until we receive your completed claim form.

Customer Services
Freephone: 0800 169 7733
free from a UK landline or mobile phone
Office hours: Monday to Friday, 9am to 5.30pm
Calls will be charged at standard local rates

E-mail

Website

Combined Insurance
PO Box 683
WINCHESTER
SO23 5AH

Financial Ombudsman Service

Corporate member of Plain English Campaign 445
Committed to clearer communication

UK Sickness claim form (W)

Customer Account number

Combined Insurance seeks to pay all genuine claims. We check all claims carefully to identify fraudulent or exaggerated claims. This keeps the cost of insurance down for everyone.

We exchange information with other insurers and take other measures to prevent fraud. Please be aware that making a fraudulent or exaggerated claim can lead to prosecution. You can call our Fraud Hotline in complete confidence on 020 8541 6085 if you think a false claim is being made. Thank you.

Section A – to be completed by you

- **Please answer all questions in full to help us process your claim.**
- Complete all sections with a **ballpoint pen** in **black ink** and **CAPITAL LETTERS.**

1 Personal details (insured)

Important note: is the claim for an insured person under 18? Yes [X] No [X]

If **Yes**, the insured's parent or legal guardian must fill in this form, starting at **1.1**. If **No**, go to **1.3**.

1.1 Full name of parent or legal guardian

1.2 Relationship to insured (e.g. father)

Full name of insured:

1.3 Date of birth D D M M Y Y Y Y

1.4 Address

Postcode

1.5 Home phone number

Mobile number

Work number

E-mail Address

1.6 Are you? Self-employed ☐ Employed ☐ Other (please tell us, e.g. student, retired)

1.7 What is your job or occupation (e.g. plumber, courier)

Please tell us any other jobs that you are paid for

2 Details of sickness

2.1 Please tell us the full details of the sickness you are claiming for

2.2 What date did you first notice symptoms of your sickness? D D M M Y Y Y Y

2.3 If your sickness has been diagnosed, please tell us what it is.

2.4 What treatment or medication did you have **at first**, but are no longer having, for your sickness?

2.5 What treatment or medication are you having for your sickness **now**?

2.6 What treatment or medication did you have, or are you still having, for your sickness?

2.7 Have you ever suffered a similar sickness? Yes [X] No [X]

If **Yes**, please tell us the full details. Please include the date when you first noticed symptoms of your sickness, details of the treatment you received and information about recovery.

3 Loss of time

Total loss of time – your condition must prevent you from carrying out each and every duty of your usual business or occupation (or usual activities if not engaged in business or employment).

3.1 Has the sickness prevented you from performing all of your usual working activities (or usual activities if not in paid employment)? Yes [X] No [X]

If **Yes**, go to question 3.2 If **No**, go to question 3.4

3.2 Between what dates have you been unable to perform all of these activities?

From [D][D][M][M][Y][Y][Y][Y] To [D][D][M][M][Y][Y][Y][Y]

3.3 Please describe in **full** the activities you cannot perform. **How** is the sickness stopping you from performing these duties?

Partial loss of time – your condition must prevent you from carrying out one or more important duties of your usual business or occupation (or usual activities if not engaged in business or employment).

3.4 Has there been a time since your sickness when you have returned to work, but have been unable to carry out all of your working activities (or your usual activities if you are not in paid employment)?

Yes [X] No [X]

If **Yes**, go to question 3.5 If **No**, go to section 4 (Hospital treatment)

3.5 Between what dates have you been unable to perform all of these activities?

From [D][D][M][M][Y][Y][Y][Y] To [D][D][M][M][Y][Y][Y][Y]

What date did you go back to work? [D][D][M][M][Y][Y][Y][Y]

3.6 Please describe in **full** the activities you cannot perform. **How** is the sickness stopping you from performing these duties?

4 Hospital treatment

4.1 Did you attend a hospital as a result of your sickness? Yes X No X

If **Yes**, go to question 4.2 If **No**, go to section 5 (Your doctor)

4.2 If you were an **inpatient*** at hospital please confirm the dates you were **admitted** and **discharged and attach a copy of your hospital admission/discharge summary.**

Date admitted D D M M Y Y Y Y Date discharged D D M M Y Y Y Y

**Someone who is admitted to a hospital ward and stays at least one night.*

4.3 What treatment did you receive?

4.4 Did you have an operation when you were in hospital? Yes X No X

If **Yes**, when did your doctor refer you for surgery? D D M M Y Y Y Y

When were you first seen by the consultant / specialist? D D M M Y Y Y Y

Please give us full details of the surgery you had:

4.5 Please provide the name and address of the hospital and the specialist you saw for your treatment**

Full name of specialist

Hospital name and address

Postcode

*** If you attended more than one hospital or saw more than one specialist, please provide further details on a separate sheet and enclose with your claim form.*

5 Your doctor

5.1 Please provide the full name and address of your doctor (GP)

Full name of doctor (GP)

Practice name and address

Postcode

5.2 How long have you been with this practice? Years Months

5.3 Please confirm the dates you visited your doctor for the sickness you are claiming for:

First attendance D D M M Y Y Y Y Second attendance D D M M Y Y Y Y

Third attendance D D M M Y Y Y Y Fourth attendance D D M M Y Y Y Y

Fifth attendance D D M M Y Y Y Y Sixth attendance D D M M Y Y Y Y

6 Data Protection Act, Access to Medical Reports, statement of truth and claims payment

6.1 Data Protection Act

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

6.2 Access to Medical Reports (please see Guidance Notes booklet)

- I have read the declaration, important notes and information relating to my rights under the Access to Medical Reports Act.
- I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may assess my claim.
- You may gather relevant information from other insurers about any other claims that I have made.
- I authorise those asked to provide medical information when they see a copy of this consent form.
- This form allows you to gather medical reports within six months of the date of my claim, or after my death to support my claim.
- This information can also be used to maintain management information for business analysis.

☐ **I DO** wish to see the report before it is sent to Combined Insurance.

☐ **I DO NOT** wish to see the report before it is sent to Combined Insurance.

Cross one box only. If you do not cross a box, we will assume you do not wish to see the report.

Full name* _____ Date D D M M Y Y Y Y

Signed _____

** If the insured is under the age of 18, the parent or legal guardian should complete the declaration.*

6.3 Statement of truth

- I understand that by returning this completed claim form, Combined Insurance shall not be held to admit the validity of any claim presented, or to have waived any of its rights in defence of any claim arising under the terms of the policy.
- I declare that the information provided within this claim form is true to the best of my knowledge and belief.
- I have sought to provide all information relating to my claim and I understand that telephone calls made to and from Combined Insurance's Claims and Customer Services Department may be recorded for training and claims validation purposes.

Full name* _____ Date D D M M Y Y Y Y

Signed _____

** If the insured is under the age of 18, the parent or legal guardian should complete the declaration.*

6.4 Claims payment

If the claim has been approved we will pay the claim payments directly into the bank account used to pay premiums, provided:

- The account is in your name;
- If the insured is under 18, the account is in the name of the parent/guardian

If you pay premiums from more than one bank account please confirm the last 4 digits of the account you would prefer to be credited: ☐ ☐ ☐ ☐

This payment method is speedier and safer than by cheque. If you do not pay your premiums by direct debit or if one of the above does not apply, we will pay by cheque.

Section B – to be completed by your doctor

- **This certificate must be completed by the patient's doctor, at the patient's expense.**
- Please answer all questions in full to help us process the claim.
- Complete all sections with a **ballpoint pen** in **black ink** and **CAPITAL LETTERS.**

1 Patient's details

1.1 Last Name

1.2 First names

1.3 Date of birth D D M M Y Y Y Y

1.4 Address

Postcode

2 Patient's claim details

2.1 Is the patient's claim due to an **accident** [X] ? or **sickness** [X] ? (cross one)

2.2 Please give **full** details of the **injury or injuries caused by the accident** or the **sickness diagnosis and symptoms***

** If left or right limb, please specify.*

2.3 Please confirm the date of the **accident** or the date of onset of the **sickness condition**

D D M M Y Y Y Y

2.4 What date did the patient first consult you due to the **accident** or **sickness**?

D D M M Y Y Y Y

2.5 What was the cause of the **accident** or **sickness**?

3 Loss of time

- The patient's policy may cover **total disability**. To qualify, their condition must prevent them from being able to perform each and every duty of their usual business or occupation (or usual activities if not engaged in business or employment).

3.1 Given the **above definition**, was the patient **totally disabled**? Yes [X] No [X]

If **Yes**, go to question 3.2 If **No**, go to question 3.5

3.2 Between what dates has the patient been unable to perform **any** of their usual working duties (or daily activities if they are not in paid employment)?

From D D M M Y Y Y Y To D D M M Y Y Y Y

3.3 Please state how the patient's injury(ies) or sickness prevents them from performing **any** of their usual working duties or daily activities

3.4 Has the patient returned to work? Yes [X] No [X]

If **Yes**, please state the date they first returned to work D D M M Y Y Y Y

If **No**, when do you think the patient will be able to return to work or usual daily activities?

Full-time D D M M Y Y Y Y Part-time D D M M Y Y Y Y

- The patient's policy may also cover **partial disability**: to qualify, their condition must prevent them from being able to perform one or more important duties of their usual business or occupation (or usual activities if not engaged in business or employment).

3.5 Given the **above definition**, was the patient **partially disabled**? Yes [X] No [X]

If **Yes**, go to question 3.6

If **No**, go to section 4 (Hospital treatment)

3.6 Between what dates has the patient been unable to perform **some** of their usual working duties (or daily activities if they are not in paid employment)?

From D D M M Y Y Y Y To D D M M Y Y Y Y

3.7 Please state how the patient's injury(ies) or sickness prevents them from performing **some** of their usual working duties or daily activities

4 Hospital treatment

- The patient's policy may cover inpatient **hospitalisation** if they were admitted for an overnight stay in hospital.

4.1 Was the patient admitted to hospital for an overnight stay? Yes [X] No [X]

If **Yes**, go to question 4.2

If **No**, go to question 4.5

4.2 Between what dates was the patient confined in hospital as an in-patient?

From D D M M Y Y Y Y To D D M M Y Y Y Y

From D D M M Y Y Y Y To D D M M Y Y Y Y

4.3 Please provide the name of the consultant who attended the patient and the full name and address of their hospital

4.4 Please state all the dates the patient attended your surgery or hospital for this **accident** or **sickness**:

First attendance D D M M Y Y Y Y Second attendance D D M M Y Y Y Y

Third attendance D D M M Y Y Y Y Fourth attendance D D M M Y Y Y Y

Fifth attendance D D M M Y Y Y Y Sixth attendance D D M M Y Y Y Y

4.5 Please provide details of all treatment or medication received in respect of the **accident** or **sickness:**

4.6 If symptoms are still present, what is your treatment plan for ensuring your patient can return to their usual activities?

4.7 Has the patient suffered the same or similar sickness or condition previously, or a sickness or condition which may, directly or indirectly, delay recovery? Yes X No X

If **Yes**, please provide full dates and details.

4.8 Was the patient under the influence of alcohol or drugs at the time of the sickness? Yes X No X

If **Yes**, detail alcohol levels (if known)

5 Doctor's declaration and statement of truth

- I believe that the facts I have given in this statement are true and that the opinions I have expressed are correct.

Full name of doctor

Qualifications

Address

Postcode

Phone Date D D M M Y Y Y Y

Doctor's Signature

Surgery or hospital stamp

Making a Claim

Please keep these Guidance Notes in a safe place and retain for future reference.

Please read these Guidance Notes, as they contain advice that will help you to complete your claim form and information concerning how we will handle your claim. In addition, this guide also contains information relating to the **Access to Medical Reports Act 1988.**

Notification of a claim:

Please note that under the Terms and Conditions of your Policy you must notify us within 30 days from the date of an accident/sickness, or as soon as reasonably possible thereafter. Failure to do so could mean that we will be unable to accept your claim. The sending out of this claim form does not mean your claim will be paid. Please complete and return the claim form as soon as possible. Do not wait until you return to work, as this may delay the processing of your claim. We will consider your claim once we have received your fully completed form.

How to complete the claim form:

Where the claim is for an insured **person under 18,** Section A must be completed by the parent or legal guardian on their behalf.

Section A - to be completed by you

Please ensure that you fully complete this part of the claim form, answering all sections that relate to you. Failure to complete all relevant parts of Section A will cause a delay in our handling of your claim, as it may be necessary for us to contact you for the missing information.

Section B – to be completed by your doctor

Please arrange for your doctor to complete the Doctor/Hospital's Statement. Please note that any charge made by your doctor for the completion of Section B is not covered by your Policy.

Data Protection Act, Access to Medical Reports and statement of truth consent form

Please ensure that you sign and date the Access to Medical Reports and Data Protection Act consent section, which is 6.1 and 6.2. This gives us your permission to obtain a medical report, or other information that we require from a third party, in order that we can consider your claim. Please read the consent carefully, sign and date it, and tick the relevant box to confirm if you wish to see your doctor's report before it is sent to our Chief Medical Adviser. Please also read the Detailed Wording of the Access to Medical Reports Act 1988 opposite, which explains your rights under the Act. Please note we are unable to consider your claim without your consent.

Glossary of terms

Insured: The person who holds insurance cover with us and who is claiming.

Total loss of time: Where you are prevented from performing **each and every duty** of your usual business or occupation (or usual activities or activities of daily living if not in paid employment).

Partial loss of time: Where you are prevented from performing **one or more important duties** of your usual business or occupation (or usual activities or activities of daily living if not in paid employment)

How we will handle your claim

We understand that suffering an event that gives rise to a claim can be a difficult time for you. We will do our best to honour our policy promises and make your claim as easy as possible.

After we receive your claim form we will send you confirmation within five working days. We aim to respond to all correspondence within 10 working days. Our Claims Adjustors can guide you through our claims process and will keep you informed if we need additional information. It may be necessary for a Claims Adjuster to contact you.

If you have any questions or concerns about your claim please write to us or call between 9am and 5.30pm and we will do our best to provide an answer by the end of the next working day.

How to contact us or to make a claim

Please contact the Customer Services Department on 0800 169 7733 (free from a UK landline or mobile) or email us at csd@uk.combined.com

How to complain

If you would like to register a complaint please call us on 0800 169 7733, email complaints@uk.combined.com or write to Customer Services Department, Combined Insurance, PO Box 683, Winchester, SO23 5AH.

We will try to deal with your complaint as quickly as we can, but if we can't give you an immediate answer, we will write to confirm we are investigating your complaint and to let you know who you can contact about it. We will also update you on progress regularly.

Our aim is to give you a full response within eight weeks or possibly sooner. We will write to you explaining why we have accepted or rejected your complaint and, where appropriate, offering to take action or provide compensation. If we can't give you a final response in eight weeks, we will write explaining why and when we expect to be able to.

If you are unhappy with the way we dealt with your complaint or we are unable to deal with it within eight weeks, you can refer the matter to the Financial Ombudsman Service (FOS) within six months of the date of our final response. The contact details of the Financial Ombudsman Service are:

The Financial Ombudsman Service,
Exchange Tower,
London
E14 9SR,
Phone: 0800 023 4567,
Email: complaint.info@financial-ombudsman.org.uk
Website: www.financial-ombudsman.org.uk

This does not affect your right to take legal action at a later stage.

Access to Medical Reports Act 1988

(or in relation to Isle of Man, Access to Health Records and Reports Act 1993)

Important notice – please read carefully

Before signing the Access to Medical Reports Act consent in the claim form, you should know that you have certain rights under the Act. These are set out below, but the main points are as follows:

a) You can withhold your consent

b) You can see the report before it is sent to us, or during the 6 months after that

c) You can ask the doctor if he will amend any part of the report, which you consider to be incorrect, misleading or incomplete. If the doctor is not prepared to amend it, you may attach your comments in writing.

d) The doctor can withhold from you the report, or any part of it, if he thinks you would be harmed by seeing it

We would point out that should you exercise your statutory right to withhold your consent, we would be unable to give further consideration to your claim.

Detailed wording

Before we can apply for a medical report from a doctor who has cared for you, we need your consent by signing Section 6.2 of the claim form. Before doing so, however, you should read this note carefully, as it sets out your rights under the Access to Medical Reports Act 1988 and the procedures for dealing with reports. You do not have to give your consent but if you do, you can say whether you wish to see the report before it is sent to the company's Chief Medical Adviser. If you do not give consent, we may be unable to proceed with your claim.

If you say you wish to see the report, we will tell you at the same time as we write to the doctor, and we will tell him/her that you wish to see the report. You will then have 21 days to contact the doctor about arrangements for you to see the report.

Of course, the quicker you act, the quicker your claim can be considered. If you do not say you wish to see the report, we do not have to notify you if we apply for one. However, if, before such a report is sent to us, you write to your doctor saying you wish to see it, you will then have 21 days to contact the doctor about arrangements for you to see the report. Whether or not you say you wish to see the report before it is sent to us, the doctor must let you see a copy for up to six months after it is supplied, if you ask.

If you ask the doctor for a copy of the report, he/she can charge you a reasonable fee to cover his/her costs. Once you have seen a report before it is sent to us, the doctor cannot submit it until he/she has your consent. You can write to the doctor asking him/her to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your views on any part where you and the doctor are not in agreement and which the doctor is not prepared to alter.

The doctor is not obliged to let you see any part of a report, if, in his/her opinion;

- it would be likely to cause serious harm to your physical or mental health or that of others,
- or would indicate the doctor's intentions towards you,
- or if disclosure would be likely to reveal information about, or the identity of, another person who has supplied information about you unless that person has consented,
- or the information relates to, or has been supplied by, a health professional involved in caring for you.

In such cases, the doctor must notify you and you will be limited to seeing any remaining part of the report. If it is the whole of the report which is affected, they must not send it to us unless you give your consent.

COMBINED INSURANCE

Customer Services

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Email

csd@uk.combined.com

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