IRE Accident 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 the Irish Insurance Federation (IIF) and take other measures to prevent fraud. Please be aware that making a fraudulent or exaggerated claim can lead to prosecution. You can call the Irish Insurance Federation Fraud Hotline in confidence on 1890 333 333 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 accident

2.1 Please tell us the date D D M M Y Y Y Y

and the time of the accident : X am X pm (cross one)

2.2 Please tell us the full details of the **injury** caused by the accident

2.3 Where were you when the accident happened? Please tell us the specific place or address.

2.4 What were you doing when the accident happened?

2.5 What caused the accident to happen?

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

2.7 Have you ever had a similar injury? Yes X No X

If **Yes**, please tell us the full details. Please include the date of the injury, details of the treatment you received and information about your recovery from the injury.

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 injury 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 injury 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 injury 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 **only some** 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 injury stopping you from performing these duties?

4 Hospital treatment

4.1 Did you attend a hospital as a result of your injury? 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 Were you admitted to intensive care? Yes X No X

If **Yes**, date admitted to intensive care D D M M Y Y Y Y

date discharged from intensive care D D M M Y Y Y Y

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

If yes, please give us full details of the surgery you had:

4.6 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 surgery? ☐☐ Years ☐☐ Months

5.3 Please confirm the dates you visited your doctor for the injury 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 Personal Data, statement of truth and claims payment

6.1 Data Protection Act

In order to process your claim we may be required to pass your Health/Medical details to our reinsurers and/or Regulatory Bodies. It may also be necessary to supply them with a copy of your original Policy Application. As required by the Data Protection Act we request your consent to forward this data. **Your signature below will signify this consent**. Failure to do so may prevent us from settling the claim to your satisfaction. Your personal data will only be used to administer your claim or policies and will not be used for any other purpose by the reinsurers. 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/ie-en/footer/privacy-policy.aspx or by searching 'Privacy Policy' on http://www.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.

You have the right to ask for a copy of any personal data and/or sensitive personal data held about you (for which we may charge a small fee) and to have any inaccuracies in such personal data and/or sensitive personal data corrected. If you wish to avail of this right, please contact our Head Office, address on back page.

- I consent to Combined Insurance being provided with personal data and sensitive personal data, concerning the admission and continuation of the claim, including but not limited to information concerning any physical and/or mental health or condition from any third party.
- I acknowledge that by signing this notice, Combined Insurance shall be regarded as having obtained my consent to the uses and disclosures of my personal data, including sensitive personal data, as set out above.

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

Signed _____ ** If the insured is under the age of 18 the declaration should be completed by the parent or legal guardian*

6.2 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 declaration should be completed by the parent or legal guardian*

6.3 Claims payment

If we approve your claim, we can credit the money directly into a personal bank account which is in your name (not a business account). This method is quicker, safer and more reliable than payment by cheque. As such, we would be grateful if you could your bank details below:

Name of Account holder(s) _____ Sort Code _____ Account Number _____

Name of your Bank or Building Society _____ IBAN _____

If your bank details are not provided above and you pay your policy premiums by direct debit, we will pay directly into the bank account used to pay your premiums, provided this is a personal account in your name. If not, 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 : [X] am [X] pm (cross one)

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**?

2.6 If a fracture occurred, please state bone(s) fractured?

2.7 Has the fracture been confirmed by an x-ray? Yes [X] No [X]

If **Yes**, please attach a copy of the x-ray report. If **No**, please advise basis of clinical diagnosis.

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 If the patient was admitted to intensive care, please confirm dates.

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

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

4.5 Was an invasive surgical procedure performed? Yes X No X

If Yes, please give details including the date of the procedure and the hospital where it was undertaken

4.6 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

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

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

4.9 Has the patient suffered the same or similar injury or condition previously, or an injury or condition which may, directly or indirectly, delay recovery? Yes X No X

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

4.10 Was the patient under the influence of alcohol or drugs at the time of the injury? Yes X No X

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

4.11 If the patient has suffered loss of sight, speech or hearing, is this permanent? Yes X No X

If **Yes**, state percentage (%) of loss.

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

What to do next...

1. Have you completed **all the relevant sections** and signed the claim form?
2. Have you carefully read, then signed and dated **6.1** and **6.2** (Data Protection Act and statement of truth). Please also read and complete section **6.3** (claims payment).
3. Has your doctor **completed and signed section B**?
4. If you have been admitted as an inpatient to a ward, have you enclosed your hospital admission/ discharge summary sheet(s)?
5. If you have completed all of the above, please 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. Please read and retain your claim Guidance Notes.

Customer Services

Main switchboard: 01 269 6522
Facsimile: 01 283 8585
Office hours: Monday to Friday, 9am to 5pm

E-mail

csd@ie.combined.com

Website

www.combinedinsurance.ie

Address

Sedgwick, Merrion Hall
Strand Road
Sandymount
Dublin 4

Making a Claim

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.

Notification of a claim:

Please note that under the Terms and Conditions of your Policy you must notify us of a claim event covered under the terms of your policy. We recommend you to do so as soon as reasonably possible as in certain circumstances, any delay could mean that we are unable to consider your claim. The issues of this claim form is not an admission of your claim.

To avoid a delay in our handling of your claim, please complete the claim form immediately. Do not wait until you return to work, as this will delay the processing of your claim.

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.

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

Please arrange for a doctor who attended you in respect of your accident or sickness to complete the **Attending Physicians Statement**. Please note that any charge made by the doctor for the completion of this form is not covered by your Policy.

Access to Medical Records and Data Protection Act consent form:

Please ensure that you sign and date the “Declaration and Authorisation to Release Information” consent section, which is at the end of page 1. This gives us your permission to obtain a medical report, or other information that we require from a third party, to enable us to consider your claim. Please read the consent carefully, sign and date it. Please note we are unable to consider your claim without your consent.

How we will handle your claim:

We will aim to respond to you within 10 working days of receipt of your completed claim form. We will keep you informed should we find it necessary to obtain additional medical information or any other information to assist us in our handling of your claim. During our handling of your claim, it may be necessary for us to arrange for you to attend an independent medical examination, but if we do, we aim to arrange for the independent medical examination to take place close to where you live. We will pay the fees direct to the independent medical examiner.

If a payment is due on your claim and you do not provide us with your bank details in section 6.3 of this claim form, and you pay your policy premiums by direct debit, we will pay directly into the bank account used to pay your premiums, provided this is a personal account in your name. If not, we will pay by cheque.

How to contact us:

If you have any questions at any time in relation to your claims, please contact the **Customer Service Department, Combined Insurance**, Sedgwick, Merrion Hall, Strand Road, Sandymount, Dublin 4; Telephone our Customer Service Department on 01 269 6522 or email csd@ie.combined.com

How to complain:

If you ever need to complain, please contact our Customer Services Department at the above address. If we cannot resolve the matter immediately, we will, within 5 business days of receiving your complaint, inform you of the person who will deal with your complaint and when you can expect to receive a further response. If we are unable to provide you with a response within 20 business days, we will write explaining why this is the case.

If after 40 business days we are not in a position to issue a final response we will write to you explaining why and indicate when we expect to provide full and final response. In addition we will provide you with details for the Financial Services and Pensions Ombudsman to investigate on your behalf. The contact details of the Financial Services and Pensions Ombudsman are:

Financial Services and Pensions Ombudsman

Lincoln House,
Lincoln Place,
Dublin 2, DO2 VH29

Phone : 01 567 7000
Fax : 01 662 0890
Email : info@fspo.ie
Website : www.fspo.ie

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

Customer Services

Phone:

01269 6522

Office hours:

Monday to Friday, 9am to 5pm

Email:

csd@ie.combined.com

Website:

www.combinedinsurance.ie

Addess:

Sedgwick, Merrion Hall, Strand Road, Sandymount, Dublin 4