CHUBB

Chubb European Group Limited
Claims Department
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Claim form

Helping Hand Cancer Care

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 details

Title	Forename(s)	Surname

Email address	Date of Birth (DD/MM/YY)

Full address

Postcode

Telephone no. business	Telephone no. home

Illness details

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

Illness details (continued)

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

Please provide the name and contact details of your treating consultant

Hospital statement – (only to be completed if claiming hospitalisation benefit)

This section must be fully completed by hospital staff or records department – 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.

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:

Please give full details of illness:

Final diagnosis (to include staging):

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 cancer diagnosed?

Was the patient hospitalised as a result of this condition? Yes: ☐ No: ☐

Is there any additional information that you feel is relevant?

Please provide copies of histology results or hospital letter confirming same.

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.

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** ______________________

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: ______________________

____

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______________________ Postcode ______________________

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

Account Number ______________________

Account Name (s) ______________________

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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 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.

Please return the completed claim form together with any enclosures to:
Chubb European Group Limited, Claims Department, PO Box 4511, Dunstable, Bedfordshire LU6 9QA

Chubb. Insured.℠

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