

Claim form

Helping hand personal accident

Thank you for notifying us of your claim.

Please complete all questions – if any question is not applicable please mark “N/A”.

Please ensure that you sign the declaration on this claim form.

Policy number	Policy number

Main Policyholder details

Title	First name	Last name
<hr/>	<hr/>	<hr/>
Email address		Date of Birth (DD/MM/YY)
<hr/>		<hr/>
Full address		
<hr/>		
		Postcode
<hr/>		<hr/>
Contact no. (day)		Contact no. (eve)
<hr/>		<hr/>

Employment details

What is your occupation?

Please describe your duties:

Name & Address of employer:

Email address of employer:

Accident/Sickness details

Please give exact date and time when injured or taken ill: Date: _____ Time: _____ am/pm

Please state fully:

a) Where the accident occurred: _____

b) How the accident occurred: _____

c) The injuries sustained: _____

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 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

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 _____

If the patient has been seen by a consultant/specialist, please provide name and full address

On what date did incapacity commence? _____

Is patient still incapacitated? Yes: No:

If **YES** when will patient be able to return to work or previous activities if not working? _____

Are there likely to be any permanent effects of the injury Yes: No:

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

Name _____

Date _____

Position held in Hospital: _____

Qualifications: _____

Please use validation stamp or complete in block capitals:-

Name: _____

Address: _____

Telephone No: _____

Validation stamp

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.

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: _____

Postcode _____

Bank Sort Code

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IBAN _____

BIC _____

Account Number _____

Name of Account Holder (s) _____

Data protection

Protecting your privacy is very important to Chubb European Group Limited ("Chubb"). Any information that you or your medical representative provides in the claim form and/or Doctor's Statement is "sensitive data" as defined by the Data Protection Acts of 1988 and 2003. 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 and its group companies. It may be held in 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 and private investigators 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 Ireland, 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. Guidelines for sharing of information in this regard are contained in a Code of Practice on Data Protection for the Insurance Sector which has been approved by the Data Protection Commissioner.

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

Name _____

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.

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.SM

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UK0030X-A_Helping Hand Personal Accident