Chubb European Group Limited
Claims Department
PO Box 1086
Belfast
BT1 9ES
claims@chubb.com

Claim form

Personal accident/sickness

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.

Policy number

Main Policyholder details

Title | **First name** | **Last name**

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

Full address

Postcode

Contact no. (day) | **Contact no. (eve)**

For security purposes please provide a password which will be required to access your claim information
This is for additional security and you may be asked for it when calling Chubb.

Insured persons details

Full name	Date of birth (DD/MM/YY)	Relationship to main policy holder	I intend to claim on behalf of: (✓) where applicable
MAIN POLICYHOLDER AS ABOVE			

Employment details

What is your occupation?

Please describe your duties:

Name & Address of employer:

Email 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

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 staff or records – any fee for completion of this section is the responsibility of the beneficiary of insurance

a) Type of hosptal/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:-

Validation stamp

Hospital Name: _____

Address: _____

_____

Telephone No: _____

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 beneficiary of insurance

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

Qualifications: _____

Please use validation stamp or complete in block capitals:-

Validation stamp

Hospital Name: _____

Address: _____

_____

Telephone No: _____

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

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

Account Number _____

Name of Account Holder (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

_____ _____

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.℠

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