

Barclays Insurance Dublin Accident, Sickness & Hospitalisation Claim Form



Agreement Number

Once you have filled in all the relevant sections of the attached claim form,
please use the envelope provided or post to:

Firstplus Claims Service
Barclays Insurance Dublin
PO Box 300
London
W4 5TD

Claim Number (for official use only)

Tel: 0870 600 0141*

Please remember the following:

- 1 You must continue to make payments under your credit agreement while we (Barclays Insurance Dublin) are assessing your claim.
- 2 Sending you this claim form does not mean that we will accept your claim.
- 3 If we accept your claim, we will backdate your payments to the date the claim became valid.
- 4 A company representative may visit you during the period for which you claim (if applicable).
- 5 Please fill in this form in black ink and in BLOCK CAPITALS.

Instructions

This guide will help you fill in the claim form accurately so we can process your claim quickly.

If you do not fill in all of the relevant sections of this form, this may cause delays in processing your claim.

We may need to return the claim form to you for you to fill in the missing sections.

If you have any questions about the claim form or need help, please phone us on 0870 600 0141.*

It may help you to tick the boxes next to each item below to confirm that you have provided all of the information that we need.

Put a line (or write 'N/A') through any sections which do not apply to your claim.

Please keep a copy of your claim form and any other information you send us, for your own records.

If you want to give us any more information to support your claim, please attach this on a separate sheet.

- Fill in sections A and B2 or B3 fully.
- Please ask your employer to fill in section B1 (if relevant).
- Please ask your GP or medical practitioner to fill in section C.
- Read and sign sections D and E.



* To make sure we maintain a high-quality service, we may monitor or record phone calls.

Calls to 0870 numbers are charged at your national rate. Additional charges may apply when using a mobile phone or when calling from abroad.

A Your details

Name

Address and postcode

Please tick if you would like us to use this address for all correspondence.

Home phone number

Mobile number

(We will confirm by text message that we have received your claim form. We may also use this number to contact you about processing your claim.)

Date of birth / /

National Insurance number

Please list all other policies you hold with us.

Start date of insurance Policy number

B Employment status (when the accident or sickness began). Please fill in either section B1, B2 or B3.

B1 Employed (Your employer must fill this in if you were employed at the start of the Disability.)

Occupation

What was the first date that the employee's accident or sickness prevented them from working? / /

Is their job still open? Yes No

If 'No', what date did it end? / /

If their job is not open, what are the reasons?

When do you expect them to return to work? / /

Your name

Company address and postcode

Phone number

Fax number

Name
(in BLOCK CAPITALS)

Signature

Position

Date / /

Company registered number

Company stamp
(or evidence on company headed paper or a business card)

Or

B2 Self-employed (if you were employed at the start of the Disability.)

What is your occupation? VAT number or tax reference

What was the first date that your accident or sickness prevented you from working? / /

When do you expect to return to work? / /

Or

B3 Unemployed, student, retired, homemaker, other (fill in if you were NOT employed at the start of the Disability.)

Are you:
unemployed? a student? retired? a homemaker? other? If 'other', please give details.

What was the first date that the accident or sickness prevented you from carrying out your normal daily activities? / /

C Disability details (Your doctor must fill this in regardless of employment status.)

Please ask your doctor to fill in all sections in **BLOCK CAPITALS**.
You must pay any cost involved in your doctor providing this information.
Please make sure that all details are filled in

Patient's full name

Patient's date of birth / /

Date they joined the practice / /

What condition or symptoms are currently preventing the patient from working or carrying out their normal daily activities? If it was an accident, please supply details.

What was the first date they consulted you about this condition or the symptoms of this condition? / /

What date did you diagnose this condition? / /

What was the first date you signed a certificate for this condition? / /

Did the patient have symptoms, consult a doctor, receive treatment or medication for this condition (even if a diagnosis was not made) during the 12 months before the start date of this insurance? (See Section A.)

Yes No

If 'Yes', has the customer been free of symptoms for this condition for two years before the certified date? Yes No

If 'Yes', has the customer been free of medication for this condition for two years before the certified date? Yes No

Does the patient suffer from more than one condition which contributes to this disability?

Yes No

If 'Yes', please list the conditions, with the most serious first.

Is the patient's sickness or injury due to a self-inflicted injury, alcohol or drug abuse, surgical procedures and medical treatment performed for cosmetic reasons, civil commotion, riot or war?

Yes No

If 'Yes', please give details.

Has the patient been referred for treatment in a hospital?

Yes No

Was the patient an in-patient?

Yes No

If 'Yes', please give dates.

From / / To / /

Name of hospital

Consultant's name

In your opinion, when will the patient be fit to work again or carry out their normal daily activities? / /

Doctor's name

Address and postcode

Phone number

Fax number

Doctor's stamp

I confirm the patient named above is, at the date of this claim form, unable to do their job or carry out their normal daily activities due to the sickness or accident described above.

Doctor's signature

Date

/ /

D Access to Medical Reports Act 1988

Your rights under this act – please read carefully.

Before we, or our appointed agents, can apply for a medical report from your doctor, we need your permission. Before giving your permission below, you should know that you have certain rights under The Access to Medical Records Act 1988. These include the following:

- a You can withhold your permission to a medical report being applied for.
- b You can see the report before it is sent to us. If you ask to do this, either by filling in the slip below or by contacting the doctor yourself, your doctor cannot send the report to us without your permission or unless you fail to contact them within 21 days about seeing the report. The 21 days begins when the doctor first receives our request.
- c You can ask the doctor to change any part of the report, which you consider to be incorrect or misleading. If the doctor does not agree, you may ask the doctor to attach a statement of your views to the report.
- d The doctor does not have to let you see any part of a report, which in their opinion would be likely:
 - to cause serious harm to the physical or mental health of you or others;
 - to show the doctor's plans for your treatment; or
 - to reveal information about the identity of another person who has supplied information about you (unless that person has agreed, or the information relates to, or has been supplied by a health professional involved in your care).

In these cases, the doctor must contact you and you will only be able to see any parts of the report which are not affected. If the whole report is affected, you may not see it. However, the doctor may not send it to us unless you agree.

- e You can ask the doctor to see their report within six months after they sent it to us.
 - We may not be able to go ahead with your claim if there is no medical information. We would appreciate your help giving the information to us as quickly as possible.
 - The doctor is entitled to charge you a reasonable fee to cover their costs of supplying any report to you.

f Permission to release medical records.

By getting your full medical records we can make a full assessment of the claim. To avoid possible delays at the claims stage, please sign the declaration below. If we need full medical records, we can apply for them immediately. We, or our appointed agents, can apply for the records and an appointed medical practitioner can complete the review. You also have the same rights under the Access to Medical Records Act 1988, including those mentioned above, when it comes to releasing these medical records.

g Permission to get a medical report and release medical records.

I am aware of my rights under the Access to Medical Reports Act 1988.

I consent to you and your appointed agents who act on your behalf, requesting medical information in relation to this claim and from doctors who I have attended, at any time, concerning anything which affects my physical and mental health. I agree that copies of this consent form will be equally valid.

In some instances we may require the full medical records in order to make a full assessment of the claim.

Your declaration

- You may release my full medical records (both past and present) for you or your appointed agents to review this claim and under the policies to which the claim relates.

Please tick one box.

I want to see medical reports before they are sent to you or your appointed agents.

I do not want to see medical reports before they are sent to you or your appointed agents.

Your signature:

Date:

E Notice and declaration

Notice

Insurers share information with other insurers to prevent fraud. We may pass the information you supply on your application form and any other information about your claim to other insurers.

Your declaration

- The information I have given is true. If any of the information I have given or which is given for me is incorrect, I understand that you will be able to take away my rights under my policy.
- I agree that any employer, ex-employer, employment service or anyone else you ask, can give you information about me for this claim.
- I understand that I must give you evidence to prove that my claim is valid. I understand that I must give HM Revenue & Customs all the information they need to work out any tax I may owe arising from you paying claim benefits.
- Copies of this declaration will be legally valid.

You may hold or release the information on this form (and any person you have authorised may do so) for the purpose of my insurance. This includes providing, processing, handling claims and preventing fraud. It could also include passing details to other insurers. You may ask other insurers for information to check the information I have given.

Your signature:

Date:

Please print your name here.