Cassidy Davis

Accident & Sickness Claim Form

INSTRUCTIONS - IMPORTANT - PLEASE READ CAREFULLY

1. Please answer all the questions in FULL and in BLOCK CAPITALS.
2. Section A has to be completed by YOU.
3. Section B has to be completed by the Human Resources Department of your employer or, if you are self employed, by your Accountant.
4. Section C has to be completed by your Doctor. Any charge for completion of this section is your responsibility.
5. Section D has to be completed by YOU.
6. Section E has to be completed by YOU.

The form when completed should be returned to the Scheme Administrators, Cassidy Davis Insurance Services Ltd, 21 Perrymount Road, Haywards Heath, West Sussex, RH16 3TP

FOR OFFICE USE ONLY

RF

CD

MB

J1

J2

STAMP

Account No.

To prevent fraudulent claims insurers share information with each other via a Register of Claims. The information you supply on this form, together with the information you have supplied on any application form that you may have completed and any other information relating to the claim, will be provided to other Register participants.

SECTION A - Your Personal Details - to be completed by YOU

Your title: Mr ✓ Mrs ✓ Miss ✓ Ms ✓ Other title

Your surname

Your first name(s)

Your home address

Postcode

Your telephone numbers

Home

Mobile

E-mail Address

If you have supplied either a mobile number or an email address we may use these as an alternative to regular postal services to ensure a speedy and accurate delivery.

Where the terms of your cover allow, claims payments may be made directly into your bank account. Please give us details of the account you would wish to be credited.

Your Bank Sort Code

Your Bank Account Number

Claim Number (for office use only)

Your date of birth

Your Pay Roll Number with your last employer

Your National Insurance number

Your occupation

Are you self-employed? YES ✓ NO ✓

Name and Address of your employer or business if self-employed.

Postcode

How many hours do you work each week?

How long have you been with your employer? Years Months

Date when you expect to return to work (if known).

Date when you last worked prior to your accident or sickness.

SECTION A - continued

When did you first seek medical attention in relation to your disability?

If you have worked for less than 12 months with your existing employer please provide full name and address of previous employer together with the period of time you worked for this employer.

Years | Months

Previous Employer

Postcode

Have you previously claimed benefit under this insurance? If YES, please provide details.

YES ✓ NO ✓

Details

Are you covered for benefits under any other payment protection policy? If YES, please provide details.

YES ✓ NO ✓

Details

DATA PROTECTION

Except as authorised in Section E Cassidy Davis Insurance Services Ltd will not discuss your claim with anyone else without your permission. This includes your spouse, partner, any other relative or friend, or your legal advisor. If you want to give us permission to talk to another person(s). Please provide their details.

Name	**Relationship**

SECTION B - to be completed by the Human Resources Department of your employer if you are employed. If you are self employed, this form should be completed by your accountant.

Employee's /Client's Name (BLOCK CAPITALS)

Date employment/self employment commenced

Date last worked prior to accident or sickness

Gross basic annual salary/income

Employers/accountants name and address

What is the nature of employment?

Permanent ✓ Temporary✓

Fixed term ✓ Sub Contractor✓

Other (please detail below)

How many hours is the employee contracted to work each week?

Official Stamp (if no stamp is available we will accept a signed endorsement on company headed paper)

Officials Signature

Position held

Officials Name

Date

SECTION C - Doctor's statement - to be completed by your Doctor

Any charge for completing the form is the responsibility of the patient.
Instructions To Your Doctor - please complete this section in BLOCK CAPITALS.

Patient's full name and address

Postcode

Please give details of the nature and extent of the illness or injuries sustained. (Please continue on a separate sheet if necessary)

Date unfit for work

Date patient first consulted you for present disability

Have you provided certification continuously since that date? Yes ✓ ☐ No ✓ ☐

If NO, for what period(s) have you not provided certification, and why?

Has the patient suffered from this or any other associated complaint, prior to this period of disability? Yes ✓ ☐ No ✓ ☐

If YES, please give dates and types of treatment.

At the time of the accident or commencement of the sickness was the patient suffering from any illness or disease? Yes ✓ ☐ No ✓ ☐

If YES, please give details with medication prescribed and advise whether this will retard recovery of present disability.

Is the disability directly or indirectly due to self-inflicted injury, consumption of alcohol, drug abuse, childbirth, pregnancy, war, riot, civil commotion, contamination by radioactivity or HIV related illnesses, including AIDS? Yes ✓ ☐ No ✓ ☐

If YES, please provide details.

If the patient is suffering from a back complaint is there x-ray evidence of abnormality? Yes ✓ ☐ No ✓ ☐

If YES, please give details.

If the patient is suffering from a mental or nervous condition are they receiving care and attention from a psychiatric specialist or psychiatric nurse? Yes ✓ ☐ No ✓ ☐

If YES, please give dates and types of treatment.

When do you expect the patient to return to work?

If the patient has already returned to work, please state the date?

Certification

I certify that the patient is / was under medical attention and in my opinion is / was totally disabled from working for wages or profit from his / her normal occupation

from ____ to ____ (if known)

How long has the patient been registered with you?

Doctor's Signature

Doctor's Name (Block Capitals)

Date

Doctor's or Medical Centre's Official Stamp

SECTION D - MEDICAL CONSENT - to be completed by YOU

Your usual doctor's name

Address of your doctor

Postcode

Telephone number (please include the dialling code)

How long have you been registered with this doctor?

Years	Months

If we need to apply to your doctor for a medical report in relation to this claim, it is a legal requirement that we obtain your consent. Before you sign this form, it is important that you understand the following points.

Under the terms of the Access to Medical Reports Act 1988, you have the following rights:

1. You can withhold your consent. Should you decide to do this, however, we may be unable to continue with your claim.
2. You can see the medical report before it is sent to us, or during the six months that follow. If you advise us that you wish to see it, we will notify you when it is issued and you will have 21 days to contact your doctor and make arrangements to see it. If you advise us that you do not wish to see it and then change your mind, you may still see it by contacting your doctor. Your doctor may charge you for providing a copy.
3. You can ask your doctor to change any part of the report you consider to be incorrect or misleading. If your doctor does not agree to this, you may attach your own comments to the report.
4. On seeing the report, you may withdraw your consent to it being sent to us, but we shall be unable to continue with your claim.
5. Your doctor can withhold part or all of the report from you, if he or she thinks you would be harmed by seeing it.

CONSENT TO OBTAIN A MEDICAL REPORT

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, and, in connection with my insurance claim hereby consent to Cassidy Davis Insurance Services Ltd seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health, and I agree that a copy of this consent shall have the validity of the original.

If it should be necessary for the Scheme Administrators to approach my doctor for a medical report:-

* I DO NOT WISH TO SEE THE MEDICAL REPORT
or, (*delete as appropriate)

* I DO WISH TO SEE THE MEDICAL REPORT.

CLAIMANT'S SIGNATURE DATE

NOTE: Access to medical reports will facilitate the fair and accurate assessment of your claim. If you wish to see the medical report, this may delay consideration of your claim.

SECTION E - DECLARATION OF THE INSURED

I declare that to the best of my knowledge and belief the answers given above are true and I understand that if I have knowingly made a false representation any benefit payments made shall be invalidated.
I authorise Cassidy Davis Insurance Services Ltd to make any necessary enquiries and obtain any information they consider relevant from my past and present employers, the Department of Health and Social Security or other appropriate sources.
I authorise Cassidy Davis Insurance Services Ltd. to make available to my finance company information regarding this claim.
I understand that my Evidence of Cover document, which I am enclosing, will be returned to me.
I consent to the seeking of information from other insurers to check the answers I have provided and I authorise the giving of such information for such purposes.

Data Protection
By signing this declaration I am allowing the Jubilee group of companies which include Cassidy Davis Insurance Services Limited, and their agents, to process my claim using the information I have provided. I understand and agree that they may respond to enquiries by the Police concerning my policy or claim in the normal course of investigations.

Where it is necessary to administer your policy efficiently or protect your interests, we may disclose the data you have supplied to other third parties, such as a solicitor, loss adjuster, loss assessors of other Insurers or Re-Insurers. This may involve the transfer of your information to countries which do not have data protection laws. You should show this notice to anyone insured under the policy, about whom personal data has been supplied. The data will not be passed to any other parties, other than those disclosed on this form. It is important that the data you have supplied is up to date. If you ask we will let you know what information we hold and provide a copy in line with the Data Protection Act (a fee is payable).

CLAIMANT'S SIGNATURE DATE