Individual Personal Accident Claim Form

Once completed, please return your claim form to:

ONE Claims Ltd
1-4 Limes Court
Conduit Lane
Hoddesdon
Hertfordshire
EN11 8EP

Thank you for notifying us of your claim.

Please complete this claim form and return it to ONE Claims Ltd as soon as possible.
Please write in BLOCK CAPITALS.
Please provide full supporting documentation to avoid delays in processing your claim.

Insured Person/Claimant

Full name: _____

Date of Birth: _____

Occupation: (Including details of usual daily duties in connection with occupation):

_____

Claimant address: _____

_____

_____

Postcode: _____

Email: _____

Telephone: _____

Fax: _____

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Employment Details (If applicable):

Company Name: _____

Company Contact Name/Department: _____

Claimant address: _____

_____

_____

Postcode: _____

Email: _____

Telephone: _____

Fax: _____

Please provide copy of wage slips for 12 months immediately prior to date of loss i.e. Audited Accounts/Tax Returns/Wage Slips

Certificate Number (Including Prefix): _____

Insurance Broker Name: _____

Address: _____

_____

_____

Date from which you have been unable to attend your normal occupation: ___/___/___

Are you still incapacitated as a result of your Accident/Illness? Yes ◯ No ◯

If **NO**, please provide the date of your return to: Part of your Duties: ___/___/___

All of your duties: ___/___/___

Have you ever suffered from this or any connected disability, prior to the insurance commencing? Yes ◯ No ◯

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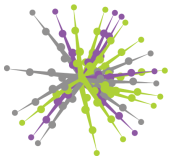

If **YES**, please provide full details including dates:

If your claim is agreed, please complete the payment details below:

Bank account (UK bank accounts only):

Bank Name:

Branch:

Bank Sort Code:

Account Number:

Account Holder:

Type of Account (Current, Gold, Platinum etc):

PLEASE PROVIDE FULL DETAILS OF THE NATURE OF YOUR DISABILITY

Accident

Date of occurrence: ___ /___ /___

Time of occurrence: ____:____am/pm

Or

Illness

Date of occurrence: ___ /___ /___

Time of occurrence: ____:____am/pm

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Please describe the circumstances leading to your accident, or cause of your illness:

Please provide the full name and address of the Doctor who attended to you and the full Name and Address of your usual Doctor if different:

Attending Doctor:

Postcode:

Usual Doctor:

Postcode:

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

Date: ___ /___ /___

Time: ____:____am/pm

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What is your expected date of return to work?

Date: ___ /___ /___

Time: ____:____am/pm

Full name of address of employer at the Commencement of disability:

_____

_____

_____ Postcode: _____

Have you previously claimed benefits under this insurance? Yes ○ No ○

If **YES**, please provide details:

_____

_____

_____

_____

I certify that the foregoing statements are correct. I understand that some of the information I have provided will be made available to other insurers for Underwriting and Claims Handling purposes. 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.

Signature(s) _____ Date: ___ /___ /_____

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Your rights – Please read carefully
Access to Medical Records & Reports

Your consent is needed before we can apply for your medical history and/or a medical report from your doctor, or other medical practitioner. This is governed by the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (made under the Northern Ireland Act 1974) and the Data Protection Act 1998.

In the event that you do not consent, we may be unable to process your claim, or continue with benefits for a claim already in existence. If you do consent then you have a choice whether or not to see the report before your doctor, or other medical practitioner, forwards it to us.

If you indicate below that you wish to see the report, you will have twenty-one (21) days after you have received our notification in which to contact your doctor, or other medical practitioner. If you indicate below that you do not wish to see the Report but later change your mind, you are entitled to request a copy directly from your doctor, or other medical practitioner, for up to six (6) months after it has been sent to us. If you are supplied with a copy of the Report your doctor, or other medical practitioner, is entitled to charge you a reasonable fee to cover costs. In addition, if your doctor, or other medical practitioner, spends time with you discussing your Report there is an additional entitlement to charge a fee to cover the time involved as this would not fall within the NHS Terms of Service.

Your doctor is not obliged to let you see any part of the report if it is felt that it would cause you harm, would indicate his intentions towards you or would reveal the identity or details of another person who is not a professional involved in your care. Your doctor, or other medical practitioner, will inform you if this applies to sections of your Report and you may see the remaining parts. If the whole Report is affected then it will not be forwarded to us without your further consent.

You are entitled to write to your doctor, or other medical practitioner, and request that your Report be amended if you consider it, or any part of it, to be incorrect or misleading. If your doctor, or other medical practitioner, is not prepared to amend your Report, a statement of your views can be attached to it.

Please tick the appropriate box, complete the form below (where applicable) and return it to us.

I wish to see the Report before it is set. ○ I do not wish to see the Report before it is sent. ○

Please complete your details

Name: _____

Address: _____

_____

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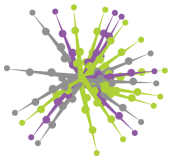

Postcode:

Signed:

Date of Signing: ___ /___ /___

Please complete medical practitioner's details:

Name:

Address:

Postcode:

Hospital Details

Name:

Address:

Postcode:

DATA PROTECTION ACT 1998

ONE Claims Ltd, will fairly and lawfully collect and record personal information that is supplied within and as a result of this form. We shall share information with your underwriters and their agents and, in certain cases, with other underwriters to help detect and prevent fraudulent claims. We require your consent to process information in this way and by completing and signing this form you are explicitly providing that consent.

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Medical Questionnaire to be completed by Claimants usual GP

The claimant must obtain, at his or her own expense, the completion of the following Certificate from a duly qualified and Registered Medical Practitioner.

Are you the usual Medical Attendant of the Claimant? Yes ○ No ○

If **YES**, how long have you been so? _____

On what date did you first attend upon the Claimant for his/her present disability? ___/___/___

On what date did you first sign the claimant as unfit for work? ___/___/___

Please confirm the nature of illness or injury sustained, together with details of the precise diagnosis and treatment being given:

_____

_____

_____

_____

_____

Has the claimant 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 illness was the claimant suffering from any other illness or disease? Yes ○ No ○

If **YES**, please give details with medication prescribed and advise whether this will retard

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recovery of present disability.

Is the disability due to self-inflicted injury, consumption of alcohol, drug abuse, childbirth, pregnancy, abortion or venereal disease or other sexually transmitted disease or HIV related illness including Acquired Immune Deficiency Syndrome (A.I.D.s) or A.I.D.S Related Complex (A.R.C)? Yes ○ No ○

If **YES**, please provide details:

Is the claimant presently confined to the house? Yes ○ No ○

Has the claimant been confined to the house since commencement of disability? Yes ○ No ○

When do you expect the claimant to return to work? Part of your Duties: ___ /___ /___

All of your duties: ___ /___ /___

If the claimant has already returned to work please state the date and whether he/she was able to return to all, or just part of his/her duties.

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DECLARATION BY DOCTOR:

I certify that the cancellation was due solely to the medical reasons stated.

From: ___ /___ /___

To: ___ /___ /___

Doctors Signature: _____

Doctors Name: _____

Qualifications: _____

Date: ___ /___ /___

Practice Stamp: