Personal Accident & Sickness Claim Form [Farm]

THE ISSUE OF THIS FORM DOES NOT IMPLY ADMISSION OF LIABILITY

This form to be completed and returned immediately to your Broker

If the Insured Person is unable to complete this form personally, it may be completed on his/her behalf

Name of Policyholder _____ Policy Number _____

Name of Claimant in full _____ Date of Birth _____

Address of Claimant _____ Business Address _____

_____

_____

Occupation of Claimant _____ Date of Employment _____

Basic Gross Weekly £ _____ Basic Net Weekly £ _____ Nat Ins No. _____

State benefits incl. Statutory Sick Pay SSP £ _____

Benefits from other Insurance Policies £ _____

Benefit Office _____

Insurers are likely to ask for written confirmation from your Employers or Accountant if Self-Employed.

Please complete either A or B

A. Personal Accident - Details of Accident

(a) Date and Time _____ (b) Where it occurred _____

(c) Full Description _____

_____

_____

(d) What injuries have you sustained? _____

Have you suffered from this before? YES ☐ NO ☐

B. Sickness

State date of first appearance of symptoms of illness _____

Have you suffered from this before? YES ☐ NO ☐

C. This section is to be completed for ALL claims together with the medical report on the next page.

(a) Due solely to this accident/illness have you been wholly unable to attend to any part of your business or occupation? YES ☐ NO ☐

(b) If the answer to (a) is 'Yes':

i) Are you still disabled YES ☐ NO ☐

ii) Dates between which you have been disabled From _____ to _____

Name and address of your usual medical practitioner _____

Name and address of medical practitioner who attended you if different _____

If incident occurred outside the UK:

Date of Departure _____ Date of return _____ Reason for trip _____

DECLARATION

I hereby declare the above particulars to be true and complete in every respect and give my consent to the Company seeking medical information from any doctor who is, or has been, attending me and earnings related information from my employer or accountant.

Signature _____ Date _____

B.I.B. UNDERWRITERS LTD • Unit 3D • Enterprise House • Valley Street • DARLINGTON • Co Durham • DL1 1GY •
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Your Rights/Access to Medical Reports Act 1988

As, under the terms of your policy, we require completion of a medical report by the doctor who is caring for you, to enable us to deal with your claim, we need your consent by signing in the space indicated below. Before doing so, however, you should read this notice carefully as it sets out your rights under the Access to Medical reports Act 1988 and the procedure for dealing with reports.

You do not have to give your consent to us being provided with the report but, if you do, you have the right to tell your doctor that you wish to see the report before it is sent to us, in which case your doctor cannot send it to us unless either he has shown it to you or 21 days have passed without you having contacted the doctor about arrangements to see it. Of course, the quicker you act, the quicker your claim can be considered and we may not be able to proceed with your claim in the absence of medical information.

Whether or not you say you wish to see the report before it is sent to us, your doctor must let you see a copy for up to six months after it is supplied to us, if you ask.

If you ask the doctor for a copy of the report, he can charge you a reasonable fee to cover his costs.

Once you have seen the report, the doctor cannot submit it until he has your consent. You can write to the doctor asking him to amend any part of the report which you consider incorrect or misleading and can have attached to the report a statement of your views on any part where you and your doctor are not in agreement but which your doctor is not prepared to alter.

Your doctor is not obliged to let you see any part of the report, if in his opinion,
(a) It would be likely to cause serious harm to your physical or mental health or that of others
(b) it would indicate your doctor's intentions towards you
(c) disclosure would be likely to reveal information about, or the identity of, another person who has supplied information about you - unless that person has consented or the information relates to, or has been supplied by, a health professional involving in caring for you.

In such cases the doctor must notify you and you will be limited to seeing any remaining part of the report. If the whole report which is affected he must not send it to us unless you give your consent.

Before signing the consent form at the foot of this form you should read the following summary of your rights and the detailed explanations above.

(a) You can withhold your consent but if you do so we may be unable to process your claim
(b) You can see the report before it is sent to us. You may request a copy of the report during the following six months.
(c) You can ask your doctor to amend any part of the report which you consider to be incorrect or misleading. If your doctor is not in agreement you may attach your comments.
(d) Your doctor can, in certain circumstances, withhold from you the report or any part of it.

I wish to see the report before it is sent to the company ☐

I do not wish to see the report before it is sent to the company ☐

* Please tick one only

Consent to obtain a Medical Report

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

Signed _____ Date _____

Name
(please print) _____ Policy No. _____

Medical Report

The claimant must obtain at his/her own expense the following report from a duly qualified medical practitioner. Failure to do so may cause a delay in dealing with the claim.

1. (a) Are you the Claimant's usual Medical Attendant? YES ☐ NO ☐ (b) If 'Yes' for how long? _____

2. When did you first attend the Claimant for the present illness/injury? _____

3. Are you still in attendance for this illness/injury? YES ☐ NO ☐

4. In the case of injuries sustained:

(a) Regions injured (if a hand or an arm, foot or leg state whether it is the right or left and whether right or left handed) _____

(b) Nature and extent of the injuries _____

(c) Are the symptoms from which the Claimant suffers due solely to the accident? YES ☐ NO ☐

If 'No', please state any other attributable cause(s) _____

5. Please provide a brief account of the Claimant's illness/injury covering onset, course and present state _____

6. (a) Has the Claimant suffered from this before? YES ☐ NO ☐

(b) Please state anything in their previous medical history which might have contributed directly or indirectly to this occurrence

_____

_____

7. Please state the period the Claimant was

(a) Confined to hospital From: _____ to: _____

(b) Necessarily confined to the bed or house From _____ to: _____

8. Pleases state your opinion as to the probable duration of such disability _____

TOTAL DISABLEMENT occurs when, through accidental bodily injury or sickness, the Claimant is immediately and continuously incapacitated from attending to his/her business or occupation.

9. (a) Are you prepared to certify that YES ☐ NO ☐ the Claimant is/has been "totally" disabled from attending to his/her business or occupation as a _____

If 'Yes' from which date did Total Disablement commence? _____

(b) If you consider disablement is only "Partial" to which portion of their duties do you feel the Claimant can attend?

_____

10. If the Claimant has recovered, please state date of recovery _____

11. General remarks _____

_____

_____

I certify that the above particulars are correct

Signature _____ Qualification _____

Address _____

_____ Date _____