ace europe

Personal Accident Claim Form

THANK YOU FOR NOTIFYING US OF YOUR CLAIM
PLEASE COMPLETE **ALL** QUESTIONS - IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE "N/A"
PLEASE USE BLACK INK AND BLOCK CAPITALS

Name of Policyholder:
Certificate/Policy No:

Full Name of Insured Person: (Mr, Mrs, Miss, Ms)	Date of Birth:
Full Address:	Postcode:
Tel No. (Business):	(Home):

EMPLOYMENT DETAILS

What is your occupation?
Please describe your duties:
Name & Address of Employer:

PLEASE ENSURE YOU SIGN THE DECLARATION ON THIS CLAIM FORM

ACCIDENT DETAILS

Please give exact date and time when injured: 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?

Please state fully:-

(a) Where the accident occurred: _____

(b) How the accident occurred: _____

_____

(c) The injuries sustained: _____

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 MEDICAL STAFF OR RECORDS
ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE INSURED PERSON

(a) Type of hospital/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: Position held in Hospital:

Date: Qualifications:

Please use validation stamp or complete in block capitals:-

Hospital Name: Validation Stamp

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 INSURED PERSON

Patient's Name: (Mr, Mrs, Miss, Ms)

Date of Birth: Height: Weight:

Please give full details of injury:

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:-

Name: Validation Stamp

Address:

Telephone No:

Thank you for your assistance in completing this form

PAYEES BANK DETAILS

When the claim has been approved you may have the payment credited direct to your Bank Account. This payment method is both speedier and safer than by cheque. If you would like to take advantage of this arrangement, please complete the following:

Name and address of your Bank:

_____Bank

Address _____

_____

_____

_____

_____Postcode_____

Branch Sort Code (from the top right hand corner of your cheque)

		—			—		

Account Number _____

Account Name(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 1988. 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 ACE Insurance S.A.-N.V. 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: _____ Date: _____

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 ACE 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 ACE
   - ❑ I **DO NOT** wish to see the report before it is sent to ACE
3. I authorise such doctor to disclose such information to ACE.
4. I agree that a copy of this consent shall have the validity of the original.

Signed: _____ Date: _____

PLEASE ENSURE (✔)

- ❑ You fully complete every question **before** your doctor completes his statement.
- ❑ You have enclosed all requested information/documentation.
- ❑ 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 your Insurance Broker or to ACE at the address shown.

Thank you for fully completing this form.