Personal Accident &/or Illness Claim Form

INSTRUCTIONS – IMPORTANT – PLEASE READ CAREFULLY

1. Please answer all questions in FULL and in BLOCK CAPITALS.
2. Section A has to be completed by YOU. Please ensure that you sign the declaration and enclose your Certificate of Insurance document.
3. Section B has to be completed by YOU after you have read the enclosed notes explaining your rights under the Access to Medical Reports Act 1988. Please ensure that you sign the declaration.
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 the PERSONNEL DEPARTMENT of your current employer. If you are self-employed please provide copies of your accounts for the last two years.
6. Please ensure that all relevant questions are answered and that all appropriate sections and boxes are completed. Failure to do so may delay the processing of your claim.
7. The form, when completed, must be returned to the Scheme Administrators: ……
8. Please insert the Insurance Broker's details in the box opposite, if appropriate.

The Insurance Broker's Details

Name

Axuda Insurance BV

Address

Rijksweg 10
6095 NB Baexem
Netherlands

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 – to be completed by YOU

Certificate Number

Surname

Title (Mr, Mrs, Etc)

First Name(s)

Date of birth

Address

Home Telephone No. (STD)

Nature of Occupation

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

Are you still totally incapacitated as a result of your accident or illness?

YES NO

Have you ever suffered from this or any connected disability Prior to the insurance commencing?

YES NO

If NO to the above, on what date did you return to:

part of your duties

all of your duties

If YES to the above, please provide full details, including dates

PLEASE PROVIDE FURTHER DETAILS OF THE NATURE OF YOUR DISABILITY AS APPROPRIATE

ACCIDENT
Date of occurrence

ILLNESS
Date symptoms first appeared

Please describe the circumstances leading to your accident

Please describe the cause of your illness

SECTION A - continued

Please provide the name and address of the doctor who attended you and the name and address of your usual doctor If different:

Attendant Doctor	Usual Doctor

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

What is your expected date of return to work? | | | | | | | | |

Full name and address of employer at commencement of disability

Have you previously claimed benefits under this insurance?
If YES please provide full details YES ☐ NO ☐

Are you covered for benefits for your disability under any other Insurance? YES ☐ NO ☐

DECLARATION OF THE INSURED

I declare that to the best of my knowledge and belief that the answers given above are true and I understand that if I have knowingly made a false representation any benefit payments shall be invalidated.
I authorities Ark Syndicate Management Limited to make any necessary enquiries and obtain any information they consider relevant from my employer, the Department of Health and Social Security or other appropriate sources.
I understand that my Certificate of Insurance, 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 providing of such information for such purposes.

Claimant's Signature Date | | | | | | | | |

SECTION B – to be completed by YOU

CONSENT TO OBTAN A MEDICAL REPORT

Please read the following wording "Access to Medical Reports Act 1988 – Your Rights Explained" before completion.

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 Ark Syndicate Management Limited seeking medical information from any doctor who at any time has attended me concerning anything which affects my mental or physical health, and I agree that a copy of this consent has 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
***I DO WISH TO SEE THE MEDICAL REPORT**
(*delete as appropriate)

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 C – to be completed by YOUR DOCTOR

Any charges 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

Date of Birth

Diagnosis

Date unfit for work

Date of first consultation for the present disability

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 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 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 patient presently confined to the house? YES NO

Has the patient been confined to the house since the Commencement of the disability? YES NO

If so, please give details

How long has the patient been registered with you?

When do you expect the patient to return to work?

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

I confirm that the patient is/was under medical attention and was totally prevented from working for remuneration or profit from his/her normal occupation

From to (if known)

DOCTOR'S OFFICIAL STAMP

DOCTOR'S SIGNATURE

DOCTOR'S NAME (Block Capitals)

DATE

SECTION D – to be completed by the PERSONNEL DEPARTMENT of your employer

If you are self-employed please provide copies of your accounts for the last two years

Employee's Name

Please advise gross basic annual salary
(this should not include bonuses &/or overtime)

Date when employee last worked prior to accident or sickness

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

Where the employee is disabled from carrying out his/her normal duties, is he/she likely to be offered alternative employment within the company?

YES NO

If YES please provide details

Official's Name

Official's signature

Position held

Date

Employer's Official Stamp

This form when completed MUST be returned to the Scheme Administrators:

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