Office G:18
Bromley Old Town Hall
30 Tweedy Road
Bromley
BR1 3FE
Tel: 02083150732
Email: **adjusters.uk@vanameyde.com**

Dear Sir/ Madam

Personal Accident & Illness

To ensure that our claims team can efficiently handle your claim, please ensure all relevant questions relating to your claim are completed

To assist in the handing of your claim you should:

- Please ensure all supporting documentation is provided, including the full policy schedule
- Please ensure that all relevant questions are answered, and that all appropriate sections, boxes and signatures are completed, failure to do so may delay the processing of your claim.
- Any questions or queries please telephone us on **0208 315 0732**

Please return the complete claim form and documentation to **adjusters.uk@vanameyde.com** or alternatively you can send to:

Van Ameyde UK
Office G:18
Bromley Old Town Hall
30 Tweedy Road
Bromley
BR1 3FE

Kind Regards

Van Ameyde UK Limited

Van Ameyde
securing your story

Personal Accident & Illness Claim Form

Section A – Claim details to be completed by the claimant

Policy number:

Start date: End date:

Title:

Full name:

Date of birth:

Address:

Postcode:

Contact number:

If providing a mobile contact please tick this box ☐ if you do not wish to receive SMS updates on your claim

Email address:

Occupation:

Date from which you was unable to attend your normal occupation:

Are you still incapacitated as a result of your accident/illness?: Yes ☐ No ☐

If **no** to the above please provide the date(s) of your return:

Part duties:

All of duties:

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

If **yes** to the above please provide full details including dates:

Date of accident: Time of accident:

Please describe the circumstances leading to your accident:

Date upon which symptoms of your illness first appeared:

Please describe the cause of your illness:

Please provide the name and address of the doctor who attended you:

Postcode:

Date of admission to hospital if applicable:

Date of discharge from hospital if applicable:

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 the commencement of disability:

Postcode:

Have you previously claimed benefits under this insurance?: Yes ☐ No ☐

If **yes** please provide full details:

Are you covered for benefits for your disability under other insurance?: Yes ☐ No ☐

If **yes** please provide details:

Section B – Access to medical records and reports

Your consent is needed before we can apply for 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 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 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.

I wish to see the Report before it is sent ☐ I don't wish to see the Report before it is sent ☐

Signature:

Date of signing: Date of birth:

Print name:

Your GP's details:

GP's name:

Address:

Postcode:

Section C – To be printed and completed by your DOCTOR

The claimant must obtain, at his or her own expense, the following Certificate from a dully 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 claimant for his/her present disability:

On what date did you first sign claimant as unfit to work?

Please confirm the nature of the 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 compliant, 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 claimant suffering from any other 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 dates:

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

Has the claimant been confided to hospital? Yes ☐ No ☐

If so please confirm admission date/discharge date:

When do you expected the claimant to return to work?

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

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

Declaration by doctor:
I confirm that the claimant is/was under the medical attention, and was totally prevented from working for remuneration or profit from his/her normal occupation from to

Doctors signature:

Doctors name:
(BLOCK CAPITALS):

Date:

Doctors Official Surgery Stamp

Section D – Payment Details

In the event that your claim is accepted and any payments are due to be made please select how you wish for the payment to be made:

Direct transfer to your account: ☐ Cheque made payment to you: ☐

If direct transfer selected please confirm the following details:

Name and address of bank:

Account holders name:

IBAN Number:

Sort code: Account number:

Section E - General Data Protection Regulation (GDPR)

By signing this claim form you consent to Van Ameyde using the information you supply, or that we collect, about you may be used by us and our agents for the purposes of claims administration, fraud investigation, management information, staff training and/or debt administration and recovery.

And to process sensitive personal data bout you where is necessary (for example health information or criminal convictions). This may mean we have to give some details to third parties involved in providing insurance cover. These may include insurance carriers, third-party claim adjusters, fraud detection and prevention services, reinsurance companies and insurance regulatory authorities.

Where such sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use by us as set out above. You have certain rights with regard to your personal data processed by us. We will ask you to provide evidence of your identify before we can take instructions to fulfil your rights.

Right of access – you have the right to access your personal data that we hold on our database about you and this can be done by making a Subject Access Request to our Data Protection Officer.

Right of rectification – if you believe the data we hold about you is incorrect, you have the right to have this corrected.

Right to restrict processing – you have the right to request us to restrict the processing of your personal data held on our database for the period it takes us to rectify any inaccurate data about you. This right can also be used to prevent us from deleting your data at the end of the retention period in the unlikely event that you need it to establish, exercise or defend a legal claim.

Section F – Declaration

I declare that the details given on this form are true and complete to the best of my knowledge. I have understood that some of the information 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.

Full name:

Signature: Date:

Please use the following area to add any additional details that could assist with handling your claim: