



**SOLA**  
Self Assured Underwriting  
Agencies Limited



# GROUP PERSONAL ACCIDENT & ILLNESS

## Group Personal Accident & Illness Claim Form

Once completed, please return your claim form to:

ONE Claims Ltd  
1-4 Limes Court  
Conduit Lane  
Hoddesdon  
Herts  
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 clearly and in BLOCK CAPITALS.

Please provide full supporting documentation to avoid delays in processing your claim.

### Company Details (The Assured)

Company name: \_\_\_\_\_

Company address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Email: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Company Contact Name: \_\_\_\_\_

### Claimant Details (The Insured Person):

Title: \_\_\_\_\_ Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Position Held: \_\_\_\_\_

Please confirm details of usual daily duties in connection with your occupation:

Please provide copy of wage slips for 12 months immediately prior to date of loss.

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CLAIMS

## Claimant Details:

Claimant address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Email: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Country of residence: \_\_\_\_\_

Certificate number: \_\_\_\_\_ Insurance Broker: \_\_\_\_\_

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

If YES, please provide full details including dates: \_\_\_\_\_

If your Claim is agreed, how would you like to be paid?

Please tick box to choose preferred method of payment:

**Cheque:**  Confirm Payee name: \_\_\_\_\_

**Or direct to your bank account**  (UK bank accounts only)

Bank Name: \_\_\_\_\_ Branch: \_\_\_\_\_

Bank Sort Code: \_\_\_\_\_ Account No: \_\_\_\_\_

Account Holder: \_\_\_\_\_

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CLAIMS

## PLEASE PROVIDE FULL DETAILS OF THE NATURE OF YOUR DISABILITY

### Accident

Date and time of occurrence

\_\_\_\_/\_\_\_\_/\_\_\_\_ :\_\_ am/pm

### Illness

Date and time upon which symptoms first appeared

\_\_\_\_/\_\_\_\_/\_\_\_\_ :\_\_ am/pm

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

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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:

### Attendant Doctor

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 Postcode: \_\_\_\_\_

### Usual doctor

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 Postcode: \_\_\_\_\_

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

\_\_\_\_/\_\_\_\_/\_\_\_\_ :\_\_ am/pm

What is your expected date of return to work?

\_\_\_\_/\_\_\_\_/\_\_\_\_

Full name and address of employer at the commencement of disability:

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 Postcode: \_\_\_\_\_

Have you previously claimed benefits under this insurance? YES/NO If YES please provide details:

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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: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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CLAIMS

## Your rights - Please read carefully

### Access to Medical Records & 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 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 sent.

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

#### Please complete Your Details

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Post Code: \_\_\_\_\_

Signed \_\_\_\_\_

Date of Signing \_\_\_ / \_\_\_ / \_\_\_\_\_

#### Please complete Medical Practitioners Details

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Post Code: \_\_\_\_\_

#### Hospital Details

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Post Code: \_\_\_\_\_

#### DATA PROTECTION ACT 1988

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.



# GROUP PERSONAL ACCIDENT & ILLNESS

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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 below.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 recovery of present disability.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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CLAIMS

## MEDICAL QUESTIONNAIRE CONTINUED:

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 below.)

Five horizontal lines for providing details if the answer is YES.

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 duties?

All of duties?

Form for 'Part of duties?' with a date field: \_\_\_/\_\_\_/\_\_\_

Form for 'All of duties?' with a date field: \_\_\_/\_\_\_/\_\_\_

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.

Five horizontal lines for providing details of return to work.

## DECLARATION BY DOCTOR:

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

from: \_\_\_/\_\_\_/\_\_\_

to: \_\_\_/\_\_\_/\_\_\_

Doctors Signature: \_\_\_\_\_

Doctors Official Surgery Stamp

Doctors Name: \_\_\_\_\_  
(BLOCK CAPITALS)

Large rectangular area for the doctor's official surgery stamp.

Date: \_\_\_/\_\_\_/\_\_\_