Personal Accident Or Illness Claim Form

Once completed, please return your claim form to:

Intana
Sussex House
Perrymount Road
Haywards Heath
West Sussex
RH16 1DN

Thank you for notifying us of your claim.

Please complete this claim form and return it to Intana as soon as possible.

Please write in BLOCK CAPITALS.

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

Insured Person / Claimant

Full name: _____

Date of Birth:

Occupation (Including details of usual daily duties in connection with occupation):

_____

Claimant address _____

_____

_____

Postcode: _____

Email: _____

Telephone: _____

Fax: _____

Personal Accident Or Illness Claim Form

INTANA

Employment Details (If applicable):

Company Name: _____

Company Contact Name / Department: _____

Claimant address: _____

_____

_____

Postcode: _____

Email: _____

Telephone: _____

Fax: _____

Please provide copy of wage slips for 12 months immediately prior to date of incident, i.e. Audited Accounts / Tax Returns / Wage Slips

Insurance Certificate Number: _____

Policy Holder / Assured: _____

Policy Holder / Assured Address: _____

_____

Insurance Broker details: _____

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:

_____

_____

_____

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Subject to claim being agreed, please complete the payment details of the policy holder:

Bank Name: _____

Branch: _____

Bank Sort Code: _____

Account Number: _____

Account Holder: _____

Type of account (Current, Gold, Platinum etc.) _____

PLEASE PROVIDE FULL DETAILS OF THE NATURE OF YOUR DISABILITY

Accident

Date of occurrence: ___ /___ /___

Time of occurrence: _____:_____am/pm

Or

Illness

Date of occurrence: ___ /___ /___

Please describe the circumstances leading to your accident, full details of the incident, 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:

Attending Doctor Name/Address: _____

_____

_____

Postcode: _____

Usual Doctor Name/Address: _____

_____

_____

Postcode: _____

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

Date: ___ /___ /___

Time: _____:_____am/pm

What is your expected date of return to work?

Date: ___ /___ /___

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

_____

_____

_____ Postcode: _____

Have you previously claimed benefits under this insurance? Yes ◯ No ◯

If **YES**, please provide details:

_____

_____

_____

_____

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Or Illness Claim Form

Your rights – Please read carefully - Access to Medical Records & Reports

Your consent is needed before we can apply for your medical history and / or a medical report from your doctor, or other medical practitioner. This is governed by the Access to Medical Reports Act 1998 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 of 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 a copy of 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 ask to see the remaining parts. If the whole report is affected then it will not be forwarded to us without 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: _____

Signed: _____

Date of Signing: ___ /___ /___

Personal Accident Or Illness Claim Form

Please complete your medical practitioner's details:

Name: _____

Address: _____

_____

_____

Postcode: _____

Telephone and Fax numbers: _____

Hospital Details (if applicable): _____

Name: _____

Address: _____

_____

_____

Postcode: _____

Telephone and Fax numbers: _____

DATA PROTECTION ACT 1998

Intana 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.

In addition, by signing this form you certify that the foregoing statements in this claim form are correct and that you understand that some of the information provided will be made available to other insurers for Underwriting and Claims Handling purposes. You consent to the seeking of information from other Insurers to check the answers you have provided and you authorise the giving of such information.

Name: _____

Signed: _____

Date of Signing: ___/___/___

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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**, causation and treatment being given/completed:

_____

_____

_____

_____

_____

Has the claimant suffered from this or any other associated medical condition prior to this period of disability? Yes ◯ No ◯

If **YES**, please give dates of the diagnosis and types of treatment:

_____

_____

_____

At the time of the accident or commencement of illness was the claimant suffering from any other illness, sickness, degenerative condition or disease? Yes ◯ No ◯

If **YES**, please states the diagnosis, the date, all treatment prescribed and advise whether this will hinder, delay or impede recovery of the claimed disability/diagnosis.

_____

_____

_____

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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 claimant presently confined to their home? Yes ◯ No ◯

Has the claimant been confined to their home since commencement of disability? Yes ◯ No ◯

When do you expect the claimant to return to work? Part of their duties: ___ /___ /___

All of their duties: ___ /___ /___

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.

_____

_____

_____

DECLARATION BY DOCTOR:

I certify that this absence has occurred solely due to the medical diagnosis claimed.

Unfit From: ___ /___ /___

Unfit To: ___ /___ /___

Doctor's Signature: _____

Doctor's Name: _____

Qualifications: _____

Date: ___ /___ /___

Practice Stamp: