CLAIM FORM

Personal Accident

ACE European Group
Claims Department
PO Box 4511
Dunstable LU6 9QA
tel: 0845 841 0059
fax: 0141 285 2901
e-mail: claims@acegroup.com

PLEASE WRITE IN BLACK INK AND USE BLOCK CAPITAL LETTERS.
ALL SECTIONS MUST BE COMPLETED OR MARKED 'NOT APPLICABLE'.
COMPLETE THE CHECKLIST AND ENSURE THAT YOU SIGN THE DECLARATION AT THE END OF THIS FORM.

Name of Policyholder	Policy no.
CLEVELAND POLICE FEDERATION	**54UK474589**

MAIN POLICYHOLDER DETAILS

Title	First name	Last name

Email address	Date of birth (DD/MM/YYYY)

Full address	
	Postcode

Contact no. Daytime	Contact no. Evening

Please complete the information below as we will need this to check your cover with the Federation Office.

☐ **SERVING OFFICER**
RANK
COLLAR/POLICE ID No.
PAY OFFICE

☐ **POLICE STAFF**
STAFF No.
PAY OFFICE

☐ **RETIRED**

For security purposes please provide a password which will be required to access your claim information
This is for additional security and you may be asked for it when calling ACE.

INSURED PERSONS DETAILS

Full name	Date of birth (DD/MM/YYYY)	Relationship to main policyholder	I intend to claim on behalf of: (✓) where applicable
MAIN POLICYHOLDER AS ABOVE			

insured.™

ACCIDENT DETAILS

Please give exact date and time when injured: DATE ______________________ TIME ______________ am / pm

If **accident** 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 beneficiary of insurance

(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 ________________________ DATE ____________

Position held in Hospital: ____________ Qualifications: ____________

Please use validation stamp or complete in block capitals:-

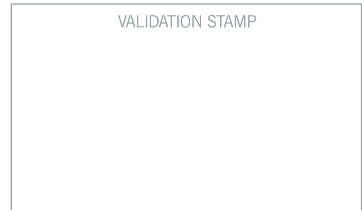
Hospital Name: ________________________

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 beneficiary of insurance

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

Date of Birth: ____________ Height: ____________ Weight: ____________

Please give full details of injury/illness: ________________________

____

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:-

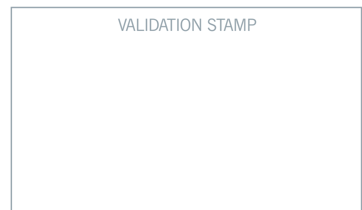
Name: ________________________

Address: ________________________

____

Telephone No: ________________________

Thank you for your assistance in completing this form.



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 ______________________

PAYEE'S BANK DETAILS

If we approve your claim, we can credit the money direct to your bank account. This method is quicker, safer and more reliable than payment by cheque. If you would like us to do this, please complete the following:-

Name of your Bank/Building Society: ______________________

______________________ *Bank*

Address ______________________

____

____

______________________ Postcode ______________________

Bank Sort Code

Account Number ______________________

Name of Account Holder(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 1998. 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 European Group Limited 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 ______________________

TO BE COMPLETED AT THE FEDERATION OFFICE Where possible please endorse with official stamp

I certify that the claimant is a member of the Scheme.

USE OFFICIAL STAMP

SIGNED ______________________ DATE ______________________

CHECKLIST

Please return the completed claim form together with any enclosures to Federation Office and please ensure...

- ☐ You fully complete every question **before** your doctor completes his statement
- ☐ You have enclosed all requested original documents (we recommend you retain copies)
- ☐ 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.

ACE European Group Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority (FCA) and the Prudential Regulation Authority reference number 202803. Full details can be found at the FCA website www.fsa.gov.uk/register/home.do or by contacting the FCA on 0800 111 6768.