# Accident & Sickness Claim Form

Please help us to assess your claim as quickly as possible: complete the claim form as much as you can and sign it. Part of this Claim Form will have to be completed by Medical Personnel. If not fully completed, we will need to send it back to you and this will delay your claim.

## Policyholder Details (Main Person on the Schedule)

Certificate / Policy Number.....(box per letter/number – 12 characters)....

Full Name..... Date of Birth ☐☐☐☐☐☐☐☐ DD/MM/YYYY

Address..... Town..... Postcode.....

Telephone Number..... Email Address.....

Occupation.....

## Claimant Details (if different from the Policyholder)

Full Name..... Date of Birth. ☐☐☐☐☐☐☐☐ DD/MM/YYYY

Address..... Town..... Postcode.....

Telephone Number..... Email Address.....

Occupation..... Relationship to Policyholder.....

## Doctors Details

General Practitioner Name.....

Address..... Town..... Postcode.....

Telephone Number..... Email Address.....

Specialist Name (if you have one).....

Address..... Town..... Postcode.....

Telephone Number..... Email Address.....

## Occupation Details

Occupation.....

Employment type (please circle): permanent, temporary, fixed term contract, apprenticeship, Self Employed

If other, please state:.....

Number of hours worked per week..... Date employment commenced? ☐☐☐☐☐☐☐☐ DD/MM/YYYY

Employer Name .....

Address..... Town..... Postcode.....

Telephone Number..... Email Address.....

## Event Details

### Accident

When did the accident happen? ☐☐☐☐☐☐☐☐ DD/MM/YYYY ☐☐☐☐☐☐☐☐ HH:MM

Where did the accident happen?.....

How did the accident occur?.....

.....

.....

.....

.....

.....

.....

What injuries did you suffer?.....

.....

## Sickness

What is the disability or condition you are currently suffering from?.....

When did the symptoms first occur and what was their nature?.....

.....

Date of Diagnosis ☐ DD/MM/YYYY

Have you ever suffered from this condition in the past? Yes☐ No ☐

if yes please confirm details of details.....

.....

## Medical Details

From when did you stop working due to your Accident / Sickness? ☐ DD/MM/YYYY

What medication are you currently taking? Please include dosage.....

.....

Are you having any non-drug therapy, e.g. physio, counselling? Yes ☐ No☐

Is this provided by the doctors named above? Yes ☐ No☐

If no please provide details below:

General Practitioner Name.....

Address..... Town..... Postcode.....

Telephone Number..... Email Address.....

Have you been assessed by the Social Security for Incapacity Benefit? Yes☐ No☐

If yes, what was the outcome?.....

If no, is an examination planned? Yes☐ No☐

If yes, please provide the date the examination is scheduled. ☐ DD/MM/YYYY

Are you expected to return to work either on a full or part time basis? Yes☐ No☐

If yes, when: ☐ DD/MM/YYYY

Have you been able to:

- Return to work? Yes ☐ No ☐
- Return to work, whether paid or unpaid? Yes☐ No ☐
- Return to work, even for short periods? Yes☐ No ☐

Which of these can you do without someone's help (please tick);

☐ Washing/Bathing: wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.

☐ Dressing/Undressing: put on, take off, secure and unfasten, all garments.

☐ Eating: feed yourself once food has been prepared and made available.

☐ Going to the toilet: use the lavatory or otherwise manage bowel and bladder function so as to maintain a satisfactory level of personal hygiene.

☐ Mobility: move indoors from room to room on level surfaces and/or walk up and down a flight of 12 stairs, with 2 feet on each stair if necessary.

STONEBRIDGE
International Insurance

# Benefit Payment Request

You accept that by Stonebridge International Insurance Ltd. making a payment in accordance with your instructions below, Stonebridge will be discharging any liability we have to you under the certificate/policy.

Please note payment will be made to the policyholder by BACS.
*IMPORTANT: We will pay to the account that we have on record to collect your premiums. If your payment is by means other than a direct debit please provide details below.*
*We will require an original bank statement to confirm your account details (account number and sort code) including your full name you're your address .*

Account Number: -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- -- --

Sort Code: -- -- -- -- -- -- -- -- -- -- --

Name of Account Holder.....

Name of Bank.....

Address..... Town.....Postcode.....

Name of Policyholder / Beneficiary

.....

Signature

.....

Date (DD/MM/YYYY)

# Claims Consent Form and waiver of patient confidentiality

Stonebridge are part of the Embignell group. In order to progress your claim and administer your policy, we need to store and process the information we collect as well as share this information with third parties who work on our behalf. This document outlines how we will use this information and asks for your consent. We need consent both from the policyholder and the claimant (the person who has suffered the loss).

Please read the conditions below and sign this form if you agree with these conditions. If you are unable to agree to these conditions, we will be unable to process your claim. This completed form must be returned with your claims form before we can begin to assess your claim.

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I understand that by signing below:

1. I declare that the information I have provided on the claims form and in any supporting documents is true and complete. Any fraud, misstatement or concealment I carry out will cause the immediate cancellation of the policy and I will lose all rights to benefits and any premiums that have been paid.

2. I consent to my personal data, including sensitive personal data (such as medical information) being processed and stored by Stonebridge for the purposes of claims assessment and validation, policy administration, service provision and fraud prevention. I understand that in order to do this my data may be shared with other members of the Embignell group and third parties working on our behalf in the UK and abroad, including outside of the European Economic Area.

3. I understand that I can withhold or remove my consent to the processing of my personal data in respect of this claim and can have any inaccuracies changed or deleted, but doing so may affect Stonebridge's ability to proceed with my claim.

I authorise Stonebridge to request, use and store any of my personal information (including but not limited to medical information) when it is necessary to handle my claim and pass my personal information (including but not limited to medical information) to third parties so that my claim can be handled in an appropriate manner.

A copy of this Consent shall be considered as valid as the original and is valid for two years from the date below.

| **Policyholder** | **Claimant (The Insured Person)** |
|---|---|
| Signature | Signature |
| Policyholder Name (Print) | Claimant Name (Print) |
| Date | Date |

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# Medical Statement *(to be completed by your GP)*

Please Note: The patient / Insured is responsible for any fee for this information.

## General Information

How long have you been the patient's usual medical attendant ☐ DD/MM/YYYY

How far do the medical records held go back? ☐ DD/MM/YYYY

What Sickness or Injury is the patient suffering from?.....

What was the date of onset of first symptoms? ☐ DD/MM/YYYY

Diagnosis..... Date diagnosis made ☐ DD/MM/YYYY

Has the patient suffered from this or a similar or a related condition previously? ☐ Yes ☐ No

If so please give dates and details.....

.....

What is the exact nature and frequency of current symptoms.....

.....

What symptoms are preventing the patient from working?.....

.....

What is the patient's prognosis? .....

.....

## Incapacity

Which of the following activities is the patient able to do (please tick all that apply);

☐ Walking: the ability to walk a distance of 200 metres on a level surface without stopping due to breathlessness, angina or severe discomfort, and without the assistance of another person but including the use of appropriate aids, for example a walking stick

☐ Climbing: the ability to walk up and down a flight of 12 stairs with the use of a handrail and taking a rest

☐ Bending: the ability to get into or out of a standard saloon car, or the ability to bend or kneel to pick up a teacup (or similar object) from the floor and straighten up again without the assistance of another person but including the use of appropriate aids

☐ Communicating: the ability to: clearly hear (with a hearing aid or other aid if normally used) conversational speech in a quiet room, or understand simple messages, or speak with sufficient clarity to be clearly understood

☐ Reading: having eyesight, even after correction by spectacles or contact lenses, sufficient to read a standard daily newspaper or to pass the standard eyesight test for driving. Failure for this activity would include being certified blind or partially sighted by a registered ophthalmologist.

☐ Dexterity: the physical ability to use hands and fingers, such as being able to communicate effectively using a pen, pencil or keyboard

☐ Responsibility and independence – the ability to independently make arrangements to see a doctor and take regular medication as prescribed by a medical practitioner, or similarly qualified medical doctor

☐ Financial competence – the ability to recognise the transactional value of money and the handling of routine financial transactions such as paying bills or checking change when shopping

From what date did the claimant meet the criteria above? ☐ DD/MM/YYYY

When will the claimant return to work either on a full time or part time basis? ☐ DD/MM/YYYY

The answers I have provided are true and complete to the best of my knowledge and belief.

Print Name.....Signature..... ☐ DD/MM/YYYY

Practice / Hospital Stamp

*Please note if this form is not stamped we will need to send it back, this causing delay to your Patients' claim*

# Employers Statement

To be completed by your employer / previous employer

| |
|---|
| Occupation Details |
| Employees' Occupation..... Job Title..... |
| Number of hours worked per week..... |
| Employment type (please circle) – permanent, temporary, fixed term contract, apprenticeship |
| Date employment commenced? ☐ DD/MM/YYYY |
| If the employee was under a fixed term or a temporary contract, please provide the details of their employment dates..... |
| ..... |
| ..... |
| Are you, the employer, deducting PAYE tax and National Insurance contributions on behalf of the employee? Yes☐ No☐ |
| Event Details |
| Incapacity |
| When were you notified that the employee was unable to carry out every duty of his/her normal occupation? ☐ DD/MM/YYYY |
| What was the last date the employee was able to work? ☐ DD/MM/YYYY |
| Has your employee notified you of the date when he/she expects to return to work? Yes ☐ No ☐ |
| If yes, please confirm date ☐ DD/MM/YYYY |
| Please provide copies of any Statutory Sick Pay forms (SSP), if these are available. |
| Unemployment |
| When was the employee first made aware of redundancy? ☐ DD/MM/YYYY |
| When did the employee first receive written confirmation that redundancy was going to occur? ☐ DD/MM/YYYY |
| On what date was the employee made redundant? ☐ DD/MM/YYYY |
| Reason for which the employee was made redundant?..... |
| ..... |
| ..... |
| Has this employee been employed with you for a continuous total period of 12 months? ☐ Yes ☐ No |
| Please sign and date the information below: |
| Print Name..... Signature..... ☐ DD/MM/YYYY |
| Position..... Email..... |
| Company Address.....Town..... |
| Postcode.....Telephone Number..... |