PERSONAL ACCIDENT AND ILLNESS/INCOME PROTECTION CLAIM FORM

Effective 08.2020

www.compassuw.com

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How to complete this claim form

Please read carefully

- Please make sure all sections are fully completed and all documents sent together. Incomplete claim forms or forms with documents missing will be returned and this may cause delays in the assessment of your claim. Please retain this page for your reference.
- Documents required from you are:
  - Copies of all the fit notes (form MED3) that you have been given by your GP or the hospital.
  - If you are an employee then we need copies of 6 months wageslips for the period immediately **prior** to you being signed off work and any evidence of bonus and overtime that you have for the 12 month period prior to you first being signed off.
  - If you are self-employed, please provide your last 2 years' accounts that have been certified by your accountant or your last 2 years' HMRC approved tax returns prior to you being signed off work.
  - Please provide evidence of any other benefits that you are receiving including incapacity benefits, statutory sick pay, income-protection, employee benefits, half-pay or other salary, pension, or from other similar insurance policies.
  - If your policy covers all or part of a mortgage, loan repayment or debt repayment or any other financial agreement, please provide us with a copy of this agreement with the relevant company along with bank statements confirming payments.

Please note that this form does not constitute acceptance of your claim by insurers or admission of any liability.

Please return the completed form and attached documents to:

Compass Underwriting Ltd, Claims Department, 30 Dukes Place, London EC3A 7LP.
Freephone number: 0800 319 6601 Fax: 020 7398 0109 Email: claims@compassuw.co.uk

Please be advised that all calls are recorded for accuracy, training and monitoring.
(We recommend that you send your claim documents by recorded delivery)

The claims process

Below are the guidelines of how to claim and the information we will be assessing with regard to your claim. Your claim will be acknowledged within 2 working days. Your claim will be processed and depending on the response times and information we receive from our enquiries, this process should be completed within 5 working days.

- Please ask your GP to complete Section D.
- Please ask your employer to complete Section F which will confirm what date you were signed off work, and to also confirm your previous income and if you are in receipt of any benefits.
- We will write to any other insurers you have detailed in this form.
- We will then assess your claim based on this information.
- We will then take your date of loss (being the first time you suffered from this condition or illness or the date of your injury). We would then apply the relevant waiting period as detailed in your certificate of insurance from the date your GP signed you off work.
- If you are off work for longer than the waiting period you may be eligible for benefits, after we apply the policy terms and conditions. We will then pay you monthly in arrears, usually within 2 working days of us receiving a fully completed continuation claim form, which will be provided by us. Please be advised incomplete forms will be returned and this may delay benefit being paid.

What information do I need to continue to provide throughout my claim?

- You must keep a copy of your GP's fit notes signing you off work and send them to us.
- **We require monthly fit notes as we expect you to be reviewed by your GP on a regular basis.** We will then continue to pay you until you either return to work or you receive the maximum benefit payable under this insurance.

You may be required to be seen by one of our consultants. If this is necessary they will contact you direct to arrange a mutually convenient time to discuss your claim.

If you send any correspondence to us please make sure you include the policy number and your full name is clearly stated.

Premiums must continue to be paid on the due date while you are in a claim situation unless otherwise informed by insurers.

We recommend that you keep a copy of your claim form and any fit notes.

Check list

Have you attached and completed all sections?

- ☐ Completed all details and signed all documents on the claim form
- ☐ Completed sections from your GP and Employer
- ☐ Copies of wage slips or certified accounts (as applicable) and your fit notes
- ☐ Details of any other benefits including other insurance policies

PLEASE DETACH ALONG PERFORATION

Personal Accident and Illness / Income Protection Claim Form

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A. To be completed by you

1. Certificate Number or Policy Number

2. Full Name

3. Date of Birth

4. Address

Postcode

5. Home telephone number

6. Mobile telephone number

7. Can we contact you via email in relation to your claim?

Yes | No

8. Email address

9. What is your occupation?

10. What is the nature of your injury/illness? If an injury describe how it occurred?

11. On what date did the injury or symptoms of your illness first appear? If an injury, provide date of accident?

12. Have you ever suffered from this injury or illness before?

Yes | No

If **YES**, when and for how long?

13. What date did you last attend your place of work?

14. From what date have you been totally unable to work?

15. When you were unable to work were you in receipt of any salary (including any half pay) other insurance benefits or pension?

Yes | No

If **YES**, what amount you have received to date?

£

16. How much is the benefit amount per month?

£

17. With regard to any salary, other income, insurances or pensions are you still awaiting a decision on what you may receive?

Yes | No

If **YES**, what is the benefit amount you expect to receive per month?

£

If YES (for Questions 15 and 17), please also complete section C

18. Have you returned to work?

Yes | No

If **YES**, please state the date you returned to work on:

£

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To be completed by you

B. DATA PROTECTION ACT/GDPR CONSENT FORM

You may wish for a family member or your legal representative to be given access to your personal and medical information in order to help you with your claim.

In order for us to be able to discuss your claim with anyone other than yourself or our appointed agents we need your specific written permission. Please note that this consent would not allow anyone other than yourself to receive any benefit payments.

You may activate or cancel your permission at any stage throughout your claim. Please contact us should you wish to make any changes.

Certificate Number or Policy Number

Do you wish for your personal information to be given out to a family member or legal representative? Yes ☐ No ☐

If **YES** then please complete the following section:

The name of your appointed family member or legal representative

Their relationship to you

Their date of Birth

Their contact address

Postcode

CLAIM FORM DECLARATION

DATA PROTECTION ACT/GDPR: I hereby consent to any information you have about me being processed by you for the purposes of providing insurance and claims handling, which may necessitate your providing such information to third parties.

AND

I hereby declare that the statements in this claim form are true in every respect to the best of my knowledge and belief and that I have disclosed all information likely to influence the assessment of my claim. I consent to the seeking of information from my present employer and any doctor who has treated me or any person/organisation that is deemed necessary, to check the answers I have provided, and I authorise the giving of such information. A copy of this authorisation shall be considered as effective and valid as the original. I understand and agree that information regarding my claim may be shared with other insurers, loss adjustors and the Benefits Agency for fraud prevention purposes and that I consent to my claim being investigated as part of this process.

Signed

Date

PRIVACY NOTICE

We act as the claims administrator and data controllers on behalf of the insurer of your policy (as defined by the Data Protection Act (including the General Data Protection Regulation).

For full details of what data we collect about you, how we use it, who we share it with, how long we keep it and your rights relating to your personal data, please refer to the Privacy Notice: for the insurer(s) at www.canopius.com/privacy/privacy-notice/ and/or www.travelers.co.uk/privacy-policy and for Compass at www.compassuw.co.uk/privacy-policy/

We will, as part of our agreement with you under this contract, collect personal information about you, including Name, address, contact details, date of birth and cover required, financial information such as bank details plus details of any claim(s). Some of this will also include sensitive personal information about you, where the provision of this type of information is in the substantial public interest, including: Medical records to validate a claim should you be claiming for sickness or an accident and wage information.

We collect and process your personal information for the purpose of insurance and claims administration without which we would not be able to assess or pay your claim. We will hold your information for six years at the completion of your claim after which it will be deleted.

THIS PAGE TO BE RETURNED TO COMPASS UNDERWRITING

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To be completed by you

C. OTHER INSURANCE(S) CONSENT FORM

Do you have any other income protection, accident/illness, loan protection, credit card protection, mortgage protection or PHI, pension or similar? Yes ☐ No ☐

Certificate Number or Policy Number

If **YES**, please state the following for each insurer who has provided you cover?

1. Name of Insurer/Pension Provider

Address

Postcode

Telephone Number for the claims/pension administration department

Policy/Claim/Pension reference number (not Compass)

2. Insurer's name

Address

Postcode

Telephone Number for the claims/pension administration department

Policy/Claim/Pension reference number (not Compass)

3. Insurer's name

Address

Postcode

Telephone Number for the claims/pension administration department

Policy/Claim/Pension reference number (not Compass)

I hereby confirm that I authorise my other insurers/pension providers, as named above, to disclose personal information about me including details about my claim/pension. A copy of this authorisation shall be considered as effective and valid as the original.

Signed

Date

Name

Address

Postcode

Date of birth

If you have more than 3 other insurers/pension providers, please provide their contact details on a separate sheet.

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To be completed by you

D. CONSENT FORM FOR RELEASE OF MEDICAL REPORTS

We may need to obtain medical reports to support your claim. Before we can ask any doctor that you have consulted to complete a report or ask for your medical records, we require your permission under the Access to Medical Reports Act 1988. Your rights under the Access to Medical Reports Act 1988 are as follows:

You do not need to give your permission but, if you do not, we will be unable to proceed with your claim.

You can ask to see the report before the doctor returns it to us. If this is the case we will ask the doctor to keep the report for a period of 21 days for you to arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you think that any part of the report is not correct or is misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will then accompany the report.

Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following:

- Your current health

  Any care, medication or treatment you are currently receiving

  The results of referrals or tests you are waiting for
- Any time off work in the last three years
- Your past health

  Details of any relevant illness, trauma or referrals for specialist advice or treatment, hospital admissions, consultations with your GP or any other medical adviser, therapist or counsellor, in particular whether you have a history of:
  - Malignancy (cancer), cardiovascular (heart) disease, diabetes and degenerative (gradually worsening) diseases
  - Musculoskeletal disease or injury, for example, arthritis, rheumatism, back problems or any other disorder of the joints or muscles
  - Anxiety, depression, neurosis (such as phobias, obsessions and so on), psychosis (a mental disorder where you lose contact with reality), stress or fatigue
  - Suicidal thoughts or attempts at suicide or
  - Conditions related to drug or alcohol misuse or smoking or chewing tobacco

  Details of any biopsies, blood tests, electrocardiograms (heart tests), height, weight if measured in the last two years, urinalyses (tests on urine), x-rays or other investigations

  Any blood pressure readings in the last three years
- Any history of disease among your parents or brothers or sisters that you have told your doctor about

We have asked your doctor not to reveal information about:

- Negative tests for HIV, Hepatitis B or C
- Any sexually-transmitted diseases unless there could be long-term effects on your health or
- Predictive genetic test results unless there is a favourable test result which shows that you have not inherited a condition your family suffers from

The information you and your doctor provide about your health may result in us:

- Refusing to agree your claim

If you have any questions about your rights under either of these Acts or relating to the process of us obtaining, assessing or storing medical information, please write to:

The Claims Manager
Compass Underwriting Ltd
30 Dukes Place
London EC3A 7LP.

I have read the details of my rights under the Access to Medical Reports Act as explained above and in connection with my insurance claim. I hereby consent to Compass Underwriting seeking medical information from my doctor who has attended me concerning my physical or mental well being in connection with this claim and I agree that a copy of this consent shall have the validity of the original.

I DO/DO NOT (delete as appropriate) WISH TO SEE THE REPORT BEFORE IT IS SENT TO COMPASS UNDERWRITING.

Your name

Certificate/Policy number

Your signature

Date

Date of birth

Your GP name

Your Consultant name

Your GP address

Postcode

Your Consultant address

Postcode

Your GP telephone/facsimile number/email address

Tel: Fax:

Email:

Your Consultant telephone/facsimile number/email address

Tel: Fax:

Email:

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To be completed by your GP

E. Medical Information

Please arrange for your GP to complete, sign, date and stamp this section. It is not acceptable for you to complete this form yourself and have it signed by your G.P.

1. Patient's Full Name

Patient's Full Address

Postcode

If more than one condition is causing this patient to be unfit for work, please list individually for each (please use a separate piece of paper if necessary)

2. Diagnosis of condition (illness or injury) that caused/causes the patient to be unfit for work.
If it is an accident please explain how it happened?

Is this a chronic condition? Yes No

3. When did the patient first consult you for the present condition or for symptoms of the present condition?

4. When was the condition first diagnosed?

5. Have you or any other medical professional treated this patient for this or any associated condition in the past or for symptoms of this condition? Yes No

If yes, please provide details including the date they first ever attended

6. Are they totally unfit to work as a result of the above condition(s)? Yes No

7. What date was the patient first certified as totally unfit for work?

8. In view of their occupation, when do you anticipate a return to work on either light or full duties?

9. Please provide details of any complications or setbacks with their recovery?

10. Has the patient been referred to a specialist or consultant, please provide:

Full Name

Address

Postcode

Telephone Number

11. Please provide copies of all relevant attendance records, hospital reports, consultant's letters and scan results for the above condition(s).

12. If caused by a back condition, please confirm whether an abnormality has been confirmed with radiological evidence?

13. If the condition is related to a psychiatric illness, mental or nervous disorder, please confirm whether the patient has been diagnosed by a consultant, or mental health professional? Yes ☐ No ☐

If yes, please confirm when the diagnosis was made?

Is this condition likely to last beyond 12 months from the date they were first signed as unfit to work? Yes ☐ No ☐

I certify the patient is (or was) receiving Medical attention , and in my opinion is (or was) totally unfit for work:

Office stamp

Doctors Name (please print)

Doctors Signature

Date

Doctors Surgery Full Address

Postcode

Telephone Number

Email Address

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Personal Accident and Illness / Income Protection Claim Form

To be completed by you and your employer

F. Employer's Information

Please complete the following questions so that your employer can identify you and provide us the information, as set out under the Data Protection Act and GDPR, as we need your consent so that we can complete our assessment of your personal accident / income protection claim.

Certificate Number or Policy Number

Your Date of Birth

Employer's Company Name

Your Employee/Identification or Payroll number

Your Name

The name of the person completing this form

Their position

Employer's address

Postcode

Telephone number for contact person

Email address

I hereby confirm that I agree in authorising my employer, as named above, disclosing personal information about me to Compass Underwriting Limited and agree that a copy of this consent shall have the validity of the original.

Signed by Employee

Date

Could your Employer please complete the following questions:

Date employment started

Please state annual gross salary before deductions and including any bonus/overtime

£

When did the employee first sign off sick?

Is the employee back full-time? Yes No

If yes, what date did they start back?

Did the employee return part-time or on light or reduced duties? Yes No

If yes, please give dates. From: To:

I hereby confirm that the information given above is true and accurate to the best of my knowledge and belief.

Signed by Employer

Date

Compass Underwriting Ltd.
Claims Department, 30 Dukes Place, London EC3A 7LP.
Tel. 0800 319 6601 Fax. 020 7398 0109
Email. claims@compassuw.co.uk Website. www.compassuw.com

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