Arch | Insurance

Travel Claim Form

Accident & Sickness

Pursuing Better Together®

Guidance Notes – Accident and Sickness

Most delays in settling claims arise because claim forms are not fully completed or requested documents are not sent to us. We would therefore ask you to answer all questions (dashes and spaces cannot be accepted).

You should read and sign the declaration and refer to the guidance notes overleaf for details of what we require.

If you are unable to supply any of the requested documents, please include a separate note explaining why this is, to enable us to help you more quickly.

IMPORTANT: PLEASE READ CAREFULLY Please answer all the questions in **FULL** and in **BLOCK CAPITALS**.

If you are claiming for temporary total or temporary partial disablement, please provide payslips or copy accounts confirming details of your Gross Weekly wage for the 52 week period prior to the date of the accident or onset of the sickness.

Section A has to be completed by **YOU**. Please ensure that you sign the Claim Form, and enclose your Certificate of Insurance Document.

Section B has to be completed by your **DOCTOR**. Any charge for completion of this section is your responsibility.

Section C has to be completed by **YOU**, after you have read the notes explaining your rights under the Access to Medical Reports Act 1988.

Please ensure that all relevant questions are answered, and that all appropriate sections and boxes are completed. Failure to do so may delay the processing of your claim.

The form when fully completed must be returned to your Insurance Broker, who arranged this insurance for you. They will forward it to Arch Insurance UK Personal Accident and Travel.

SECTION A: To be completed by the claimant

If you are unable to complete this form personally, due to your disability, it may be completed on your behalf.

Policy No.		Policyholders Name	
Insured Person's Surname *(including any titles)*			
Date of Birth		Occupation(s)	
Address			
Postcode		Tel. No.	

Please state you average gross weekly wage, calculated over the 12 months prior to the commencement of disability. £

Please state the date from which you have been unable to attend your normal occupation?

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.

Are you still **totally** incapacitated as a result of your accident/sickness? Yes ☐ No ☐

if 'no' please provide the date that you were able to undertake a) part of your duties.

b) all of your duties.

PLEASE PROVIDE FURTHER DETAILS OF THE NATURE OF YOUR DISABILITY AS APPROPRIATE ACCIDENT /SICKNESS

Date and time of Occurrence,	Date upon which symptoms first appeared,
Please describe the circumstances leading to your accident,	Please describe the nature of your sickness,

Please provide the name and address of the Doctor who attended you.

Please provide the name and address of your usual Doctor (if different).

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

During what period have you been confined to hospital? To

From What is your expected date of return to work?

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

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

If Yes, please provide full details.

Are you covered for benefits for your disability under any other insurance? Yes ☐ No ☐

If Yes, please provide full details.

I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution. I confirm that the information given on this form is to the best of my knowledge and belief, true in every respect and that I have declared and not claimed amounts refunded to me or claimed from any other source. **You must read the declaration before signing**

Signature Date

If you are not the insured person, please state your relationship to them.

SECTION B: To be completed by your Doctor

The claimant must obtain at his or her own expense the following Certificate from a 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 claimant for his/her present disability?

On what date did you first sign claimant as unfit for work?

Please confirm the nature of the sickness 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 the dates and types of treatment

Date	Treatment

At the time of the accident or commencement of sickness was the claimant suffering from any other sickness or disease? Yes ☐ No ☐

If Yes, please give details with medication prescribed and advise whether this will retard recovery of present disability

Is the disability caused by or traceable to any gradually developing bodily deterioration? Yes ☐ No ☐

If Yes, please provide full details including original date of onset

Is the disability due to Human Immunodeficiency Virus (HIV) and/or any HIV related sickness, any psychiatric, mental or nervous disorder, mental sickness, anxiety, stress or depression, self inflicted injury, drug abuse, pregnancy or childbirth related conditions? Yes ☐ No ☐

If Yes, please provide details

continued

When do you expect claimant to return full duties?

When do you expect claimant to return partial 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 YOUR DOCTOR

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

Doctor's Signature	**Date**
Doctor's Name (BLOCK CAPITALS)	

Doctor's Official Stamp

SECTION A: To be completed by the claimant

ACCESS TO MEDICAL RECORDS ACT 1988

In accordance with the Act and before we can apply for a medical report from your doctor, we need you consent. Before signing in the space below, you should know that you have certain rights under the Access to Medical Records Act 1988.

These are set out below:

(A) You can withhold your consent.
(B) You can see the report before it is sent to us or during the six months after that.
(C) You can ask the doctor if he will amend any part of the report, which you consider to be incorrect or misleading. If the doctor is not in agreement, you may append your comments.
(D) The doctor can withhold from you the report, or part of it, if he/she thinks you would be harmed by seeing it.

Name of Insured Person:
Address: Post Code:
Date of Birth:

CONSENT TO OBTAIN MEDICAL REPORT

I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution. I confirm that the information given on this form is to the best of my knowledge and belief, true in every respect and that I have declared and not claimed amounts refunded to me or claimed from any other source.

I have been informed of my statutory rights under the Access to Medical Records Act 1988. In connection with my insurance claim hereby consent to Arch Insurance UK Personal Accident & Travel instructed to deal with this claim on their behalf, being provided with medical information from any doctor; who at any time, has attended me concerning anything which affects my physical or mental health. I agree that a copy of this consent shall have the validity of the original.

You must read the declaration before signing

I wish to see the report before it is sent to the company (please tick) Yes ☐ No ☐

Signature | Date

Name of Doctor:
Address: PostCode:

IMPORTANT NOTICE TO ALL CLAIMANTS

In the event that your claim is successful, we shall most likely issue payment by BACS transfer directly into your bank account, as this is both a faster and more secure form of payment.

Can you please complete the boxes with your bank account number, bank sort code, bank name and bank address ensuring our claims reference is quoted.

Arch utilise an encrypted email system, but if your email system is not encrypted, we cannot guarantee the security of your communication and you may wish to consider alternative methods of submitting these details.

Please detach the final page if details regarding your claim need to be completed by your vet, doctor or other such professional, due to the sensitive data contained.

Name of Bank	
Branch	
Sort Code	
Account No.	
Account Name	
Claims Reference	
Signature	Date