

## **ACCIDENT CASH PLAN- HOSPITALISATION CLAIM FORM**

Please provide as much information as possible when completing this form. If you are unable to fit your answers into the spaces below, please continue on the additional sheet provided. Please ensure the patient has read and signed the Access to Medical Reports Act 1988 Consent Form. If this is not possible, a person permitted to sign on the patient's behalf should complete and sign this form. Without this consent to obtain medical information, we are unable to proceed with this claim. You must also ensure that the Doctor who attended the patient during the hospital admission has completed the appropriate section of this form. In addition to this form, we may request other information to help us fully assess this claim. Please refer to the Certificate and Schedule of Benefits for details of the benefits payable under this policy. Should you have any queries on the claims process, please call us on 0870 420 1244, Monday to Friday 8:30 a.m. to 5:30 p.m.

### **Certificate Holder's Details:**

Certificate No: _____	Date of Birth: _____
Full Name: _____	
Address: _____ _____	
Post Code: _____	Telephone No: _____

### **Patient's Details:**

Full Name: _____	Date of Birth: _____
Relationship to Certificate Holder: _____	
Address if different to the above: _____ _____	

Stonebridge Claims Unit, PO Box 2801, Stoke on Trent, ST4 9DN

Stonebridge International Insurance Ltd is authorised and regulated by the Financial Services Authority

**Details of Accident:**

Date and time the accident occurred: \_\_\_\_\_

Full details of the accident, including where it took place. Please provide copies of any police accident reports and press cuttings if applicable and available to you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If your accident occurred in any of the following circumstances please complete the appropriate section:**

**Employment:**

If your accident occurred during the course of your working duties, please provide the following details:

Nature of your employment: \_\_\_\_\_

Name and Address of Employer: \_\_\_\_\_

Employer's Telephone Number: \_\_\_\_\_

**Road Traffic Accident:**

If your injury was sustained in a road traffic accident and you are making a claim under your motor insurance policy, please provide the following details:

Name and address of insurer: \_\_\_\_\_

Telephone number of insurer: \_\_\_\_\_

Policy/Claim reference number: \_\_\_\_\_

**Accident overseas:**

If your accident occurred overseas and you are making a claim under your travel insurance policy, please provide the following details:

Name and address of insurer: \_\_\_\_\_

Telephone number of insurer: \_\_\_\_\_

Policy/Claim reference number: \_\_\_\_\_

**Police:**

If your accident was reported to or is being investigated by the police, please provide the following details:

Name and collar number of investigating police officer: \_\_\_\_\_

Address of police station: \_\_\_\_\_

Telephone number of police station/police officer: \_\_\_\_\_

Accident/Crime reference number: \_\_\_\_\_

**Please provide copies of any reports available to you.**

**Medical Treatment/Details:**

Details of injury: \_\_\_\_\_

Name and address of hospital attended: \_\_\_\_\_

Name of Doctor(s) who first provided treatment: \_\_\_\_\_

Name of Doctor(s) currently providing treatment: \_\_\_\_\_

What date was the first visit to hospital for this injury? \_\_\_\_\_

Date of hospital admittance: \_\_\_\_\_ Time of admittance: \_\_\_\_\_ am/pm\*

Date of discharge from hospital: \_\_\_\_\_ Time of discharge: \_\_\_\_\_ am/pm\*

Details of inpatient treatment received: \_\_\_\_\_

Name of the patient's General Practitioner: \_\_\_\_\_

General Practitioner's address: \_\_\_\_\_

Apart from consultations in connection with this injury, when did the patient last consult their GP? If this was in the last five years, please provide full details:

Details of all medication being taken, including dosage: \_\_\_\_\_

\* Delete as applicable

**Declaration and Authorisation:**

I declare that the above statements are true and complete to the best of my knowledge and belief.

I understand that any fraud, mis-statement or concealment will cause this policy to be of no effect and all legal rights to benefits and any premiums paid will be lost.

I authorise any Doctor whom I have consulted or who has treated me to furnish Stonebridge International Insurance Ltd. (“the Company”), or its agent with any information concerning my past physical and mental health and present condition. I also authorise the release to the Company or its agent of any other information, which the Company considers relevant to enable this claim to be dealt with.

I understand that by furnishing this form and investigating the claim or by accepting any proof of claim, the Company shall not be held to admit the validity of any claim or to have waived any of its rights in defence of any claim arising under the policy.

I understand that I may request to receive a copy of this authorisation. I agree that a photocopy of this authorisation is as valid as the original. I agree that this authorisation is valid for two years from the date shown below.

**Data Protection:**

I understand that information, including information about my physical and/or mental health or condition, which is provided to the Company in connection with this claim, may be retained by the Company and used to process the claim. The Company may also pass this information to its legal advisers, reinsurer, medical advisers or other companies we have instructed to validate the legitimacy of the claim, so that the claim can be fully administered. This information may also be passed to other insurers, the Association of British Insurers or other regulatory organisations for fraud prevention and detection purposes and to validate the legitimacy of the claim. I further understand that this information may be transferred outside of the European Economic Area by the Company or its reinsurer to the United States of America, in which data protection laws are not as comprehensive as in the European Economic Area, to assist the administration of the claim. By signing this declaration, I consent to the Company using and transferring my information as set out above.

Name in Capitals \_\_\_\_\_

Patient’s Signature \_\_\_\_\_

Dated \_\_\_\_\_

Name in Capitals \_\_\_\_\_

Certificate Holder’s Signature \_\_\_\_\_

Dated \_\_\_\_\_

\*Please ensure you read and sign the **Access to Medical Reports Act 1988** consent form at the end of this claim form.



**ACCESS TO MEDICAL REPORTS ACT 1988**

THIS SECTION MUST BE READ AND SIGNED BY THE PATIENT IN RESPECT OF WHOM A CLAIM IS BEING MADE.

To enable us to deal with this claim, it may be necessary for us to obtain confirmation of your medical history from all Doctors who have attended you.

Before applying for this information, we would advise you that you have certain rights under the Access to Medical Reports Act 1988. These are set out overleaf, but the main points are as follows:

- You can withhold your consent;
- You can see the report before it is sent to us or during the six months after that;
- You can ask the Doctor if he/she 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;

- The Doctor can withhold from you the report, or any part of it, if he/she thinks you would be harmed by seeing it.

**CONSENT TO APPLICATION FOR A MEDICAL REPORT**

I have been informed of my statutory rights under the Access to Medical Reports Act 1988.

In connection with my claim, I hereby consent to Stonebridge International Insurance Ltd or its agent, being provided with medical information from any Doctor who has attended or treated me concerning anything which affects my physical and mental health. I also agree that a copy of this consent shall have the validity of the original.

(Please tick the appropriate box.)

- I do wish to see the report before it is sent to Stonebridge International Insurance Ltd.
- I do not wish to see the report before it is sent to Stonebridge International Insurance Ltd.

IF YOU HAVE NOT TICKED EITHER BOX, WE WILL ASSUME YOU DO NOT WISH TO SEE THE REPORT.

Patient's Signature \_\_\_\_\_ Dated \_\_\_\_\_

Name in capitals \_\_\_\_\_

**PLEASE SEE OVER FOR GUIDANCE NOTES ABOUT THE ACCESS TO MEDICAL REPORTS ACT 1988**

## **ACCESS TO MEDICAL REPORTS ACT 1988 – GUIDANCE NOTES FOR INSURANCE CLAIMS**

Under the terms of this policy, we may require further medical reports by the Doctor who is caring for you. To enable us to obtain this report, we need your consent by signing in the space overleaf. Before doing so, however, you should read this note carefully, as it sets out your rights under the above Act and the procedures for dealing with reports.

You do not have to give your consent to enable us to obtain a report, but if consent is not given, we may be unable to proceed with the claim. If you do give your consent, then you have the right to tell the Doctor you wish to see the report before it is sent to us, in which case the Doctor cannot send it to us unless he/she has either shown it to you, or 21 days have passed without you having contacted your Doctor about arrangements for you to see it. We would point out that the quicker you act, the quicker this claim can be considered.

Whether or not you say that you wish to see the report before it is sent to us, the Doctor must let you see a copy for a period of up to six months after the report was supplied.

If you ask the Doctor for a copy of the report, he/she may charge you a reasonable fee to cover his/her costs.

Once you have seen the report and before it is sent to us, the Doctor cannot submit it until he/she has your consent. You can write to the Doctor asking him/her to amend any part of the report which you consider to be incorrect or misleading and have attached to the report a statement of your views on any part where you and the Doctor are not in agreement and which the Doctor is not prepared to alter.

The Doctor is not obliged to let you see any part of the report if, in his/her opinion, that would be likely to cause serious harm to your physical or mental health or that of others or would indicate the Doctor's intentions towards you, or if disclosure would be likely to reveal information about, or the identity of, another person who has supplied information about you unless that person has consented or the information relates to or has been supplied by a health professional involved in caring for you. In such cases, the Doctor must notify you, and you will be limited to seeing the remaining part of the report. If it is the whole report that is affected, the Doctor must not send it to us unless you give your consent.

## ATTENDING DOCTOR'S STATEMENT

(THE CERTIFICATE HOLDER IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION)

### Patient's Details & Authorisation to release information: (to be completed by the certificate holder or patient)

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address including postcode: \_\_\_\_\_

I hereby authorise the undersigned Physician to release any information acquired in the course of my examination or treatment.

Patient's Signature \_\_\_\_\_ Dated \_\_\_\_\_

### Medical Details: (to be completed by the attending Doctor)

Please include copies of any relevant reports, including the hospital admittance report and discharge summary, if available. Alternatively, you may wish to send us the originals, and we shall copy and return these promptly to you. When answering "yes" to questions, please provide as much information as possible and, if necessary, continue your answers in the additional space provided. Your help is greatly appreciated, and if you require further information to help you complete this form, please contact us on 0870 420 1244 Monday to Friday 8.30am to 5.30pm. (excluding Bank Holidays).

Date of hospital admittance: \_\_\_\_\_ Time of admittance: \_\_\_\_\_ am/pm\*

Date of discharge from hospital: \_\_\_\_\_ Time of discharge: \_\_\_\_\_ am/pm\*

To the best of your knowledge, was the patient's condition caused by an accident? Yes  No

If yes, date the accident occurred: \_\_\_\_\_

If yes, please confirm the circumstances of the accident: \_\_\_\_\_

Full details of treatment given: \_\_\_\_\_

If surgery was performed, please provide full details, including dates: \_\_\_\_\_

Diagnosis of present condition: \_\_\_\_\_

Long-term prognosis: \_\_\_\_\_

Is the patient suffering from any other disease/medical condition? Yes  No  If yes, please provide full details: \_\_\_\_\_

Is this other disease/medical condition affecting the duration of the hospitalisation? Yes  No

If yes, please provide full details: \_\_\_\_\_

Details of all medication taken by patient, including dosage: \_\_\_\_\_

*Medical Details continued:*

Has any other Doctor treated the patient? Yes  No

If yes, please provide their name, contact address and speciality: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

In your professional opinion, do you think it would help our claim assessment to obtain a report from this Doctor?

Yes  No

\* Delete as applicable

**Additional Information:**

Please use the space below to give any other relevant information or to continue your answers to the preceding questions.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Qualifications: \_\_\_\_\_

Contact Address: \_\_\_\_\_

\_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

**CERTIFICATE BENEFIT PAYMENT REQUEST**

**Important Notes:**

- Neither the issue of this form nor the acceptance of this form once completed are admissions of liability by Stonebridge International Insurance Ltd.
- This form should be completed by the Claimant(s) as set out in the in Certificate of Insurance. If there is more than one Claimant, all Claimants must complete and sign this form before any payment can be made.
- The Claimant(s) should use this form to request how payment of any monies due to the Claimant(s) will be made, whether: (a) by direct transfer into the bank account(s) of the Claimant(s) or a third party; or (b) by cheque made out to a third party.
- If a request is made for payment by direct transfer to an International Account, the cost of this transaction will be deducted from the Benefit payment directly by the bank(s).
- You accept that by making a payment in accordance with your instructions, Stonebridge International Insurance Ltd will be discharging any liability we have to you under the Certificate of Insurance.

**Please contact Stonebridge International Insurance Ltd if you are unsure as to who should complete this form.**

Certificate Number(s):	_____
Name of Insured:	_____

In the event that the claim under the above numbered Certificate(s) is admitted, I/We request that the payment of any monies due to me/us be made payable:

**To me/us/a third party, by Direct Transfer (please enter all details in BLOCK CAPITALS):**

Name and Address of Bank: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Bank Account Sort Code:        /        /        /

Swift / IBAN Number:        \_\_\_\_\_ (International Payments only)

Bank Account Number:        \_\_\_\_\_

Name of Account Holder:        \_\_\_\_\_

**To a third party by Cheque (please enter all details in BLOCK CAPITALS):**

Name of third party        \_\_\_\_\_

Address of third party        \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Claimant(s)	Name in Capitals	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____