

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.

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.

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

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?	<input type="text"/> 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 <input type="checkbox"/> No <input type="checkbox"/>	
Event Details	
Incapacity	
When were you notified that the employee was unable to carry out every duty of his/her normal occupation?	<input type="text"/> DD/MM/YYYY
What was the last date the employee was able to work?	<input type="text"/> DD/MM/YYYY
Has your employee notified you of the date when he/she expects to return to work?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please confirm date	<input type="text"/> 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?	<input type="text"/> DD/MM/YYYY
When did the employee first receive written confirmation that redundancy was going to occur?	<input type="text"/> DD/MM/YYYY
On what date was the employee made redundant?	<input type="text"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please sign and date the information below:	
Print Name.....	Signature..... <input type="text"/> DD/MM/YYYY
Position.....	Email.....
Company Address.....	Town.....
Postcode.....	Telephone Number.....

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

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

<u>General Information</u>	
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	
<u>Incapacity</u>	
Which of the following activities is the patient able to do (please tick all that apply);	
<input type="checkbox"/> 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	
<input type="checkbox"/> Climbing: the ability to walk up and down a flight of 12 stairs with the use of a handrail and taking a rest	
<input type="checkbox"/> 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	
<input type="checkbox"/> 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	
<input type="checkbox"/> 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.	
<input type="checkbox"/> Dexterity: the physical ability to use hands and fingers, such as being able to communicate effectively using a pen, pencil or keyboard	
<input type="checkbox"/> 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	
<input type="checkbox"/> 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	
<i>Please note if this form is not stamped we will need to send it back, this causing delay to your Patients' claim</i>	