Loss of Use and Permanent Total Disability

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.....

Doctor Details

General Practitioner Name.....

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

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

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

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

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

Event Details

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

Where did the accident happen?.....

How did the accident occur?.....

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What injuries did you suffer?.....

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Occupation Details

What was your occupation(s) immediately prior to your disability?.....

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Date your disability stopped you from working? ☐ DD/MM/YYYY

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

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

Telephone number..... Email address.....

Please enclose your job description. If not available, please describe your normal duties in detail.....

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Loss of Use:

Are you claiming for (please circle):

Quadriplegia Paraplegia

Loss of use of:

Hearing in both ears Sight in one eye Speech Sight in both eyes

Total, Permanent and irrecoverable loss of an entire, specific joint or limb

by separation or

by paralysis or

of movement

An entire finger An entire big toe An entire toe (other than a big toe)

Shoulder Elbow Hip Ankle

Knee Wrist Leg Arm

Other please state.....

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Permanent Total Disability

Are you permanently unable to perform any paid work whatsoever for the remainder of your life? Yes☐ No☐

If yes, please tell us when this was confirmed by the Social Security ☐ DD/MM/YYYY

Please provide details of what Social Security has confirmed.....

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Additional Information Sheet

Please provide any additional information you feel will help us process your claim

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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

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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

Medical Statement

to be completed by your GP/Specialist

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

General Information

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

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

When did you first see the claimant in connection with this loss? ☐ DD/MM/YYYY

Are you aware of any previous medical history which is likely to be associated with the present loss? Yes ☐ No ☐

If yes, please confirm details.....

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What treatment has the claimant received?.....

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Has the claimant been compliant with all treatment? Yes ☐ No ☐

If no, please confirm reasons why.....

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Do you anticipate that the claimants condition will: Deteriorate ☐ Improve ☐ Remain static ☐

Please confirm reason for this.....

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In respect of this loss has the claimant attended any hospital, consultant, doctor, carers, physiotherapy or occupational therapists.

Please provide: Name.....

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

Dates attended.....

Outcome.....

Event Details

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

Where did the accident happen? .....

What injuries have resulted from the accident? .....

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Please provide details of treatment provided.....

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Is the claimant suffering from any other illness or medical condition? Yes ☐ No ☐

If yes please provide full details.....

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In your opinion what has caused the accident?.....

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Loss of Use

Is the loss deemed to be total, permanent and irrecoverable? Yes ☐ No ☐

If yes, from which date? ☐ DD/MM/YYYY

If no, please provide details?.....

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Please provide any available supporting documents.

Total, Permanent and Irrecoverable loss by separation or paralysis or of movement of an entire, specific joint or limb

Is the claimant permanently, totally and irreversibly disabled for the rest of their life as the result of an accident and permanently prevented from performing any paid job? Yes ☐ No ☐

If yes, from which date? ☐ DD/MM/YYYY

If no, please provide details?.....

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Please provide any available supporting documents.

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 this claim