Unemployment Claim Form

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 a doctor. 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.....

Occupation Details

Occupation.....

Number of hours worked per week.....

Employment type – full time, part time, temporary contract, apprenticeship, Self Employed (circle appropriate)

If Self-Employed please complete this, for all other employment types please go to next section.

Date you are registered as self employed? ☐ DD/MM/YYYY

Date you have registered at the job centre? ☐ DD/MM/YYYY

Do you pay income tax under schedule D? Yes ☐ No ☐

Accountant Name.....

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

What is the reason for which you are no longer working?.....

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All other Employment types:

Employers Name.....

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

Date employment commenced? ☐ DD/MM/YYYY

Date you were made aware that you would be made unemployed? ☐ DD/MM/YYYY

Date were you made unemployed? ☐ DD/MM/YYYY

Have you been employed for the same employer for a continuous total of 12 months? Yes ☐ No ☐

What is the reason for which you are have been made unemployed?.....

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Have you been continuously unemployed from this date? Yes ☐ No ☐

If no, please confirm when you returned to work ☐ DD/MM/YYYY

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

CM-CFCN-EN 0.1

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? ☐ DD/MM/YYYY

If the employee was under a fixed term or a temporary contract, please provide the details of their employment dates.....

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Are you, the employer, deducting PAYE tax and National Insurance contributions on behalf of the employee? Yes☐ No☐

Event Details

Incapacity

When were you notified that the employee was unable to carry out every duty of his/her normal occupation? ☐ DD/MM/YYYY

What was the last date the employee was able to work? ☐ DD/MM/YYYY

Has your employee notified you of the date when he/she expects to return to work? Yes ☐ No ☐

If yes, please confirm date ☐ 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? ☐ DD/MM/YYYY

When did the employee first receive written confirmation that redundancy was going to occur? ☐ DD/MM/YYYY

On what date was the employee made redundant? ☐ DD/MM/YYYY

Reason for which the employee was made redundant?.....

.....

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Has this employee been employed with you for a continuous total period of 12 months? ☐ Yes ☐ No

Please sign and date the information below:

Print Name..... Signature..... ☐ DD/MM/YYYY

Position..... Email.....

Company Address.....Town.....

Postcode.....Telephone Number.....