Hospitalisation 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. 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.....

Medical Details

Hospital Name.....

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

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

Admission ☐ DD/MM/YYYY ☐ HH:MM Discharge ☐ DD/MM/YYYY ☐ HH:MM

Event Details – Please complete either the Accident or Sickness section

Accident

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

Where did the accident happen? .....

How did the accident occur?.....

.....

.....

What injuries did you suffer?.....

Sickness

Date symptoms first appeared ☐ DD/MM/YYYY

Diagnosis.....Date diagnosis made ☐ DD/MM/YYYY

Nature of your sickness?.....

Have you ever suffered from this condition in the past? ☐ Yes ☐ No

If yes, please confirm any treatment received.....

.....

While in hospital did you require any Intensive Care Treatment (ICU)? ☐ Yes ☐ No

If yes: Admission in ICU ☐ DD/MM/YYYY HH:MM Discharge from ICU ☐ DD/MM/YYYY HH:MM

☐ ☐

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

.....

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

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