compass underwriting

DISABILITY/INCOME PROTECTION
CLAIM CONTINUATION FORM

COMPLETION NOTES:
Insured: Please complete section 1 and 2
General Practitioner: Please provide a copy of your medical sick-note for the current period being claimed

IMPORTANT INFORMATION:

1. **You must fill in the correct sections of the claim form including the Declaration (section 2). Return this completed form to us as quickly as possible. If you do not return this form in time it may affect your rights to continue to receive benefit under this insurance.**
2. **Please make sure that you answer all the questions fully so that we can assess your continued claim straight away. You can use the reserve side of this sheet for any further details.**
3. **One of our appointed representatives may visit you while you are claiming. Failure to see them could invalidate or seriously delay your claim. Return this and the sick-note(s) to: Compass Underwriting Ltd, Claims Dpt, 40 Lime Street, London. EC3M 7AW. Tel 020 7398 0100 or facsimile 020 7398 0109**

SECTION 1 (to be completed by the Claimant)

Certificate No: ***66*CC****.. Date of Birth:……………… Telephone No…………………………………………*

Full Name:
....

Address:
....
………………………………………………………………………………………………Post Code…………………………………………

Have you have undertaken ANY employment of any kind during the past month? YES / NO (if "Yes" please give full details and dates)
Have you undertaken ANY courses, rehabilitation or training during the past month? YES / NO (if "Yes" please give full details and dates)
Do you receive ANY income or benefits from other insurances, the state or a pension? YES / NO. (If "Yes" please state how much benefit you are receiving per month and what the maximum benefit duration is £.................... per month for………….. from whom ....…………….

Please state the reason that you remain unable to work
……………………………………………………………………………………………………….

Or ***have you returned to work and if so, when? …………………………………………………………………………………………….***
What are your symptoms and how often do you experience them on a daily basis…………………………………………………………………..

Has your GP referred you to a specialist or consultant? YES / NO. *(if "Yes" please give full details including date of next appointment)*

Do you have problems with any of the following activities? ***If "Yes" please could full and complete details on the reverse side of this form)***

1. Walking……………………………… 2. Sitting……………………………… 3.Standing……………………………4. Driving…………………………..
5. Lifting……………………………… 6. Climbing stairs…………………… 7. Bending……………………………… 8. Exercising………………………..
9. Dressing……………………………… 10. Personal Hygiene…………………11. Shopping……………………………….

PLEASE ENCLOSE YOUR LATEST MEDICAL SICK-NOTE SIGNED BY YOUR USUAL DOCTOR OR SURGERY

SECTION 2 Declaration (to be completed by the Claimant)

Compass Underwriting is authorised and regulated by the Financial Services Authority

I hereby declare that the above statements are true in every respect to the best of my knowledge and belief and that I have disclosed all additional information likely to influence the continued payment of my claim. I consent to the seeking of information from my past and present employers, the Benefits Agency and any doctor or medical practitioner who has treated me or any person/organisation that the underwriters deem necessary, and I authorise the giving of such information.
A copy of this authorisation shall be considered as effective and valid as the original.
I understand and agree that information regarding my claim may be shared with other insurers, insurer's loss adjustors and the Benefits Agency for fraud prevention purposes and that I consent to my claim being investigated as part of this process.

DATA PROTECTION ACT 1998 I hereby consent to any information you have about me being processed by you for the purposes of providing insurance and claims handling, which may necessitate your providing such information to third parties.

Signed...***Date*** ....