

## **PERSONAL ACCIDENT & ILLNESS/INCOME-PROTECTION CLAIM FORM**

*Please note that this form does not constitute acceptance of your claim by underwriters or admission of any liability.*

Below are the guidelines of how to claim and the information we will require from you before we will start to adjudicate or look at your claim. Please refer to your insurance contract terms and conditions for a more detailed explanation.

### **What information do I need to provide?**

- You need to send us this form **within 30-days**, or as soon as is reasonably possible, if you are involved in any accident or suffers any illness which may give rise to a claim under this insurance. If you are late in sending this form to us – it could lead to delays in your claim being paid or not having your claim paid at all. We do not consider you have notified us of a claim until we receive a completed claim form back from you.
- Firstly you must complete all questions on the first part of the claim form. You must then get your GP to complete all the questions on section 2 of the form. You will need to meet the cost for this.
- You must complete the 2 consent forms so that we can write to your doctor and to your employer, for further information, as required.
- As this is an Income Protection Insurance we need to confirm your sum insured, therefore we require at least 4 consecutive months worth of your most recent wage slips to confirm your salary.
- If you are self-employed we require a copy of the last 2 years accounts, which must be certified by your accountant. If these are unavailable then we require your last 2 years worth of Inland Revenue approved tax returns.
- You must provide any other details we request that relate to your claim before we will consider any payments.
- You must be signed unfit to work by your GP and obtain a sick note from them each month which signs you unfit for work for that period. We require these on a monthly basis as we expect you to be reviewed by your GP regularly.
- If you have any other similar insurances, including mortgage protection plans, PHI, income protection, employee benefit plans, pension, credit card or loan protection plans – full details must be provided, including a copy schedule showing the amount of benefit and the name of the insurer as this could have affect on the benefits you are entitled to from us.

### **How do I claim on my Income Protection Insurance?**

- The date that your GP signs you unfit for work is usually the start date of your claim, however as this is an Income Protection Insurance you must therefore suffer a loss of income to claim under the policy.
- The waiting or deferred period as detailed in the certificate then comes into effect.
- From the end of the waiting period we pay the monthly benefits one month in arrears.
- We can only pay you benefit up to the last date you have been signed unfit for work by your GP.
- The payment is made to the claimant in the form of a cheque form and can only be sent after the month claimed has expired. (E.g. claim for 15<sup>th</sup> October 2004-14<sup>th</sup> November 2004, the cheque can only be sent from 15<sup>th</sup> November 2004.)

### **What information do I need to continue to provide?**

- Firstly you and your GP must have fully completed the claim form.
- You must then complete our Monthly Claim Continuation form - for each month that you continue to claim. We will provide this to you. If you do not receive one enclosed with your previous month's benefit cheque from us – please contact our office on 020 7398 0100 or email [london@compassuw.co.uk](mailto:london@compassuw.co.uk) or go to [www.compassuw.com](http://www.compassuw.com) (products page)
- You must provide us with copies of your **monthly sick notes** as provided by your GP. Without these we are unable to process your benefit.
- You must continue to provide us details of any payments that you are receiving, from both insurer's and the Government.

Once we have received all the necessary evidence we will process your claim monthly in arrears , usually within 10-working days of receipt of a properly completed claim form.

### **Other important information**

- Premiums must continue to be paid on the due date while you are in a claim situation
- Please make sure that you answer all the questions fully so that we can assess your claim straight away.
- One of our appointed representatives may visit you while you claim, we may also ask you to see our own independent medical consultants – failure to see them could invalidate or seriously delay your claim.
- **Please complete in BLOCK CAPITALS in blue or black ink.**
- We strongly recommend that you keep a copy of your completed claim form and your sick notes.
- **Then finally return the form to:**

**Compass Underwriting Ltd, Claims Department, 40 Lime Street, London. EC3M 7AW.**

**Tel. 0207 398 0100 Fax. 020 7398 0109.** (We recommend that you send it by recorded delivery).

*Compass Underwriting is authorised and regulated by the Financial Services Authority*

**PERSONAL ACCIDENT AND ILLNESS CLAIM FORM**  
**THE REVERSE OF THIS FORM MUST BE COMPLETED BY YOUR MEDICAL ATTENDANT**

Policy No: 66\*CC .....

Full Name:  
.....

Date of Birth:..... Home Telephone No..... Mobile Phone No.....

Address: .....

.....

..... Postcode.....

Occupation:.  
.....

Please state your average monthly income: £..... Please provide us copies of your last 4 months payslips or audited a/c's

Name and address of your employer (or your accountant if self-employed).....

..... Post Code ..... Your Employer's Telephone No.....

On what date did you last attend work?..... From what date have you been totally unable to work?.....

.....

Are you in receipt of any salary, or benefit, from your employer and if so please state how much? £..... per month

Have you returned to work? **YES / NO** If YES, please state the date you returned to work ..... on FULL / LIGHT duties.

What is the nature of your injury/illness?  
.....

.....

On what date did the accident/injury or symptoms first appear?  
.....

Have you ever suffered from this complaint before? **YES / NO** If YES, when  
.....

If injury, give date of accident and describe how it occurred  
.....

.....

Name of your usual Doctor  
.....

Date of first consultation for this complaint?..... Was this with your usual Doctor? **YES / NO**

Has any other Doctor or Hospital been consulted or treated you regarding this complaint? **YES / NO**

If YES, give Name, Address and dates:  
.....

.....

Do you have any other income protection, accident/illness, loan, mortgage or PHI, pension or similar? YES / NO. If "Yes" please state how much benefit you are receiving per month from which Insurer(s) and what the maximum benefit duration is £.....per month for..... months from ..... under policy reference(s) .....

**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 information likely to influence the assessment of my claim. I consent to the seeking of information from my present employer and any doctor who has treated me or any person/organisation we deem necessary, to check the answers I have provided, 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, 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.....

**CERTIFICATE OF MEDICAL ATTENDANT**  
**TO BE COMPLETED BY YOUR G.P.**

*This Certificate will be furnished at the expense of the Insured*

1. Patient's Name .....  
2. a) Are you the patient's usual Medical Attendant? .....  
    b) Date of first attendance for this illness/injury: .....  
3. a) Details of illness/injury sustained: .....  
    b) Diagnosis: .....  
    c) Treatment: .....  
4. Has the patient ever suffered from this complaint or any associated complaint before? .....  
    If YES, when and duration of any periods of disability .....  
5. a) If the patient is suffering from any other condition or disability, please state its nature and to what extent it affects the present disability: .....  
    b) Do any of the conditions above have any residual effect upon the patient's condition ? YES / NO  
    If YES, please clarify and has the patient full knowledge of this? .....  
6. Please give:  
    a) Dates between which complaint have caused total disability from work: From ..... To .....  
    b) Date when full duties could be resumed (if known): From ..... To .....

*ACCIDENT CLAIMS ONLY*

7. Please certify whether in your opinion this disability is due solely to the injuries as described above :      *YES / NO*

*If NO, please clarify:* .....  
.....

***I certify that to the best of my knowledge the foregoing statements are correct.***

*Signed* .....

*Address* .....

*Date* .....

.....

*Qualifications* .....

.....

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## CONSENT FORM FOR RELEASE OF MEDICAL RECORDS

**RETURN TO: THE CLAIMS DEPARTMENT, COMPASS UNDERWRITING LTD, 40 LIME STREET, LONDON, EC3M 7AW.**

It is necessary for us to obtain a copy of your medical records to support your accident/illness claim that you have made with us. Before we can ask any doctor that you have consulted to send us a copy of your records, we need your signed permission.

**Your rights are as follows:**

You do not have to give your consent, but if you do not we may be unable to proceed in the assessment of your claim and this will delay any benefits or even mean that no benefits can be paid at all.

You can ask to see a copy of your records before the doctor returns it to us. If this is the case, we will tell the doctor to retain your records for 21 days so that you can arrange to see it. If you have not made arrangements to see the report if you have not made arrangements to see the report writing this time your doctor will send the records to us. this time your doctor will send the records to us.

If you choose not to see your records at this stage, you may ask the doctor for a copy within 6 months of it being sent to us. A duplicate set of records can be sent to your doctor on request should you wish to see it at a later date.

If you consider any aspect of the records to be incorrect or misleading, you may ask the doctor to amend it. If the doctor refuses to make the amendments, you may ask him/her to attach a statement outlining your views, which will then accompany your records.

Your doctor can withhold access to your records if he feels that it would cause physical or mental harm to you or others.

Your medical records will contain details of relevant consultations, treatments, operations, investigations and test results that you have undergone at any surgery, hospital or clinic. Your consent will give the underwriters access to this information.

**I have read the details of my rights under the Access to Medical Records as explained above and in connection with my insurance claim. I hereby consent to Compass Underwriting seeking medical information from my doctor who has attended me concerning my physical or mental well being in connection with this claim and I agree that a copy of this consent shall have the validity of the original.**

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

*Your Name*

Please Print \_\_\_\_\_

The name & address of your GP \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

- **IDO / DO NOT WISH TO SEE THE REPORT BEFORE IT IS SENT TO COMPASS UNDERWRITING (\*PLEASE DELETE AS APPLICABLE)**

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## ***EMPLOYER'S CONSENT FORM***

**RETURN TO: THE CLAIMS DEPARTMENT, COMPASS UNDERWRITING LTD, 40 LIME STREET, LONDON. EC3M 7AW**

Please complete the following questions so that your employer can identify you and provide us the information, as set out under the Data Protection Act 1998, as we need your consent so that we can complete our assessment of your personal accident / income protection claim.

Your Compass Certificate Ref: 66\*CC\_\_\_\_\_

The name of your employer: \_\_\_\_\_

Their contact address: \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Your full name: : \_\_\_\_\_

Your full address: \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Your date of birth: \_\_\_\_\_

Your National Insurance Number: \_\_\_\_\_

Your full payroll number: \_\_\_\_\_

**(You must provide this information as shown on your pay advice slip)**

I hereby confirm that **I agree\* / do not agree\*** in authorising my employer, as named above, disclosing personal information about me to Compass Underwriting Limited.

**(\* Please delete as appropriate)**

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

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## ***DATA PROTECTION ACT CONSENT FORM***

**RETURN TO: THE CLAIMS DEPARTMENT, COMPASS UNDERWRITING LTD, 40 LIME STREET, LONDON. EC3M 7AW**

***You may wish for a family member or your legal representative to be given access to your personal and medical information in order to help you with your claim.***

In order for us to be able to discuss your claim with anyone other than yourself or our appointed agents we need your specific written permission. Please note that this consent would not allow anyone other than yourself to receive any benefit payments.

You may sign this form at any stage throughout your claim.

Do you wish for your personal information to be given out to a family member or legal representative **YES / NO**

If **YES** then please complete the following form:

Your Compass Policy Ref: \_\_\_\_\_

Your full name: :

\_\_\_\_\_

Your full address:

\_\_\_\_\_

Postcode \_\_\_\_\_

\_\_\_\_\_

Your date of birth: \_\_\_\_\_

The name of your appointed family member\* or legal representative:

\_\_\_\_\_

Their contact address:

\_\_\_\_\_

Postcode \_\_\_\_\_

\_\_\_\_\_

Their date of Birth: \_\_\_\_\_

I hereby confirm that **I agree\* / do not agree\*** in authorising the above representative, as named above, being given personal and medical information about me by Compass Underwriting Limited for as long as my claim shall last. This consent to be automatically terminated immediately upon completion of my claim.

**(\* Please delete as appropriate)**

**(\*Family member shall mean: husband or wife, mother or father, son or daughter only).**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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