Sentry Solutions

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Personal Accident Claim Form

Introductory Notes
If you have any queries regarding your cover or require guidance in completing this form then please contact our claims helpline on 020 8667 2467. For your protection, calls may be recorded and may be monitored.

Completion of Claim Form
Please complete all relevant parts of the form, write in BLOCK CAPITALS and tick any boxes as appropriate. In order for us to deal with your claim promptly please complete Section A of this form yourself. Please ask the General Practitioner, Hospital Consultant or Doctor attending to complete Section B of this form. Please note you will be responsible for any expenses which may be incurred in the completion of this claim form.

Declaration and Consent
Please ensure that the Policyholder and the Injured Person sign and date the Declaration and Consent at the end of the claim form. (You should sign for a person who is under 18 years of age). Please also ensure that you read the information relating to the rights under the Access to Medical Reports.

Important Notes
The questions on this form and any other questions which we specifically ask, relate to facts considered to be material to the handling of your claim. Please answer them fully and honestly and supply any additional relevant information. Failure to do so may not only invalidate this claim but also the insurance provided by the policy as a whole.

Further Guidance
Please note that if you are unable to supply any of the evidence we request, you should include a separate covering note explaining this. This will enable us to deal with your claim promptly.

Your claim form and supporting documents can be:

Emailed to: **claim@sentrysolutions.co.uk** (attachments must be in PDF or jpg format and should not exceed 2MB)
Posted to: **Sentry Solutions, PO Box 6430, Basildon SS14 0QT**

Data Protection
Please note that your personal information may be used for the purposes of insurance administration and claims handling by us, Underwriters, its associated companies, their co-insurers, the insured and their broker and other third parties advising us/Underwriters or otherwise relevant to the handling of your claim. Your personal information may be used by Underwriters and their reinsurer(s) and reinsurance broker(s) for any reinsurance claim made by them, for renewal purposes and for Underwriters'' management reporting and for internal and external audit.

It may also be used for statistical purposes, for fraud and crime prevention and may be disclosed to Lloyd's or regulatory bodies in connection with compliance with any regulatory rules or codes. Your personal information may be transferred to any country, including those outside the European Economic Area, for any of these purposes.

Section A - To be completed by the Policyholder

1. Policyholder's details

Policy number:

Policyholder's full name (Mr/Mrs/Miss/Ms):

Email address:

Daytime telephone number:

Evening telephone number:

Address for correspondence:

Date of birth:

Occupation:

Section A - Continued

2. Claimant's Details (If Policyholder state 'as above'):

To be completed in respect of the person injured (a separate claim form should be completed for each person wishing to claim).

Full name (Mr/Mrs/Miss/Ms)

Date of birth:

Address (if different from above):

Relationship to Policyholder:

Occupation:

3. Claimant's Payment Details

If we can pay your claim, we will transfer payment direct to your bank acount. Please confirm:

Account number:

Sort code:

4. Claimant's Employment Details

Are you: Employed or self-employed? (Please tick one box):

Employed ☐ Self-Employed ☐

Please provide a brief description of your duties:

If applicable, please provide the name, address and telephone number of your employer:

In order that your claim can be processed you will need to submit the following with your claim:

- If employed – Wage slips for the 12 months preceding the date of the incident
- If self-employed – your last two Inland Revenue tax assessment forms or copies of your last two audited accounts.

PLEASE NOTE: FAILURE TO SUPPLY THE ABOVE WILL DELAY YOUR CLAIM

5. Details of Accident

Location of accident:

Date:

Time:

Please give full details of the nature and severity of the injuries sustained and how the accident occurred indicating what the claimant was doing at the time:

If the accident took place at work, was it noted in the Accident Book? Yes ☐ No ☐

Please give names, address and telephone numbers of witnesses, if any:

If applicable state the type of vehicle the claimant was in and the registration number (if known):

Was the claimant a driver or passenger? Driver ☐ Passenger ☐

Did the Police attend at the time of the accident? Yes ☐ No ☐

If 'no' was the accident reported to the Police? Yes ☐ No ☐

Name of the Police Officer and address of station involved:

Accident reference number:

If a motor accident, is there any prosecution pending for drug/drink-driving? Yes ☐ No ☐

If the accident took place overseas - the date claimant left home country: Date:

Purpose of the visit:

Passport number:

Airline used and flight number:

6. Medical Care

Please note that Section B of this form must be completed by the General Practitioner, Hospital Consultant or Doctor in attendance.

Name, full postal address and telephone number of the claimant's General Practitioner:

Name, full postal address and telephone number of attending Doctor/Consultant if different from above:

Date on which the Doctor was first consulted:

Date on which the claimant last worked:

Did the insured attend a Casualty Department for treatment as a result of the accident? Yes ☐ No ☐

If 'yes' please give name, full postal address and telephone number of hospital attended:

Date attended:

7. Other Insurances

Please give details of any other Insurance claims arising from this accident, including Motor Insurance.

Name and full postal address of insurer:

Policy numbers:

Declaration and Consent

I declare to the best of my knowledge and belief all the information given in this form is complete, true and correct.

I confirm that my employers may be approached for verification of my claim and I hereby authorise them to disclose any such information requested. A copy of this authorisation shall be considered as effective and valid as the original.

If the information given on my behalf in Section B is inadequate for Sentry Solutions' purpose, I consent to Sentry Solutions obtaining a medical report from my Specialist or General Practitioner relating to the history and nature of the condition and/or its treatment.

I am aware of my rights as detailed below under the Access to Medical Reports Act 1988 and the Access to Personal Files and:

Please tick one box

I do wish to see the medical report before it is sent to Sentry Solutions ☐

I do not wish to see a copy of the medical report before it is sent to Sentry Solutions ☐

To be signed by the Policyholder in all cases.

To be signed by the Injured Person if other than the Policyholder and over 18 years of age.

Your rights under the Access to Medical Reports Act (1988) and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991

Before giving your consent for us to obtain a medical report, please ensure you read these notes carefully as they set out your rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

- You do not have to give your consent, but if that is the case we may be unable to proceed with the claim.
- If you give your consent, we will inform the Doctor of this at the time we request the medical report.
- You will then have the right to advise the Doctor, in writing, that you wish to see the report before it is sent to us. If you do this, the Doctor cannot send us the report until either:-
  a) you have seen the report and consented in writing to it being sent to us, or
  b) 21 days have passed and you have not asked the Doctor to see the report.
- It is your responsibility to make arrangements with your Doctor to see the report which has been prepared. The quicker you act the quicker we can proceed with your claim.
- Even if you did not originally wish to see the report, you can change your mind. In these circumstances, you must inform both us and the Doctor. You will then have 21 days to contact the Doctor to arrange to see the report.
- Whether or not you ask to see the report which is sent to us, you also have the right to ask your Doctor to let you see a copy, provided that you make your request within the six months after the report was sent to us.
- If you see any report, in accordance with your rights, the Doctor will need your consent before he/she can send it to us.
- If you disagree with the content of the report, you can write to the Doctor asking him/her to amend any part of the report which you consider to be incorrect or misleading.
- If you and your Doctor cannot agree on the facts set out in the report, you have the right to ask him/her to attach a statement of your views on any part of the report which you disagree with and which the Doctor is not prepared to alter.
- The Doctor is not obliged to let you see any part of the report if:-
  a) in his/her opinion, it would be likely to cause serious harm to your physical or mental health or that of others, or
  b) it would indicate the Doctors intentions in respect of you, or
  c) disclosure would be likely to reveal information about, or the identity of, another person who has supplied information about you, unless that person has consented to, or the information relates to, or has been supplied by, a health professional involved in caring for you.

In such cases, the Doctor must notify you accordingly and you will be able to see only the remainder of the report. If the whole report is affected, he/she must not send it to us unless you give your consent.

Please note that where a copy of the medical report is supplied to you, the practitioner may charge a reasonable fee to cover the cost of supplying it.

Section B - Medical Certificate

- To be completed in all cases by the General Practitioner, Hospital Consultant or Doctor in attendance NB. (Any fee is payable by the patient)

Full Name of Patient (Mr/Mrs/Miss/Ms):

Patient's date of birth:

Are you the patient's usual practitioner? Yes ☐ No ☐

If 'No' please give the name & address of usual Doctor:

Please give full details of the injuries sustained by the patient:

Please provide the final diagnosis:

When did the patient first receive medical attention for this injury?

Has the patient ever been included on a waiting list for this condititon? Yes ☐ No ☐

If 'Yes' please advise the date they were put on the list:

Please give the dates the patient has been:

Totally disabled from thier usual business or occupation.

From: To:

Partially disabled from thier usual business or occupation.

From: To:

If partially disabled, what percentage of their normal duties can they perform? %

If the patient was admitted to hospital as a result of this injury please provide:

Date and time of admission:

Date and time of discharge:

Hospital Inpatient Number:

Is the patient suffering from any other ongoing complaint that might hinder recovery? Yes ☐ No ☐

If 'Yes' please give full details:

Were the injuries treated solely as a result of the accident described in Section A of this claim form? Yes ☐ No ☐

If 'No' please give full details:

Has the patient ever suffered with this or a similar condition prior to this? Yes ☐ No ☐

If 'Yes' please advise details and dates of all previous treatments:

If disability is ongoing please provide an indication as to when you feel that the patient may be able to return to work:

If there is any additional information that you feel is relevant please provide it here:

Signature of General Practitioner, Hospital Consultant or Doctor:

Telephone number:

Name and qualifications:

Official stamp: