

# Claim form

## Personal Accident/Sickness

**Please write in black ink and use block capital letters.**

All sections must be completed or marked 'not applicable'.

Complete the checklist and ensure that you sign the declaration at the end of this form.

**Policy number**

**Main Policyholder details**

<b>Title</b>	<b>First name</b>	<b>Last name</b>
_____	_____	_____
<b>Email address</b>	<b>Date of Birth (DD/MM/YY)</b>	
_____	_____	
<b>Full address</b>		
_____		
		<b>Postcode</b>
_____		_____
<b>Contact no. (day)</b>	<b>Contact no. (eve)</b>	
_____	_____	

For security purposes please provide a password which will be required to access your claim information  
*This is for additional security and you may be asked for it when calling Chubb.*

**Insured persons details**

<b>Full name</b>	<b>Date of Birth (DD/MM/YY)</b>	<b>Relationship to main policy holder</b>	<b>I intend to claim on behalf of: (✓) where applicable</b>
Main Policyholder as above			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Employment details

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What is your occupation? \_\_\_\_\_

Please describe your duties: \_\_\_\_\_

Name & Address of employer: \_\_\_\_\_

Email address of employer: \_\_\_\_\_

Please state average annual gross and net salary over previous 12 months from the date of the incident (please enclose copies of 13 weeks payslips prior to the event) or over the previous 36 months from the date of a accident if self employed (please provide evidence of income by means of Inland Revenue Tax Assessment forms or audited accounts):

Gross: \_\_\_\_\_ Net: \_\_\_\_\_

## Accident/Sickness details

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Please give exact date and time when injured or taken ill: Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Please state

a) The date you ceased working: \_\_\_\_\_

b) The date you returned to work: \_\_\_\_\_

c) If you haven't returned to work, on which date do you hope to do so?:

If **an accident** please state fully:-

a) Where the accident occurred: \_\_\_\_\_

b) How the accident occurred: \_\_\_\_\_

c) The injuries sustained: \_\_\_\_\_

If illness please state full details of your illness: \_\_\_\_\_

Has the patient ever suffered with this or any similar condition before the present episode? Yes:  No:

If Yes, please give details \_\_\_\_\_

Have you previously claimed under this or a similar policy? Yes:  No:

If Yes, please give details \_\_\_\_\_

Please give the name, address and policy number of any other insurance that may cover this injury \_\_\_\_\_

## Hospital statement – only to be completed if claiming hospitalisation benefit

This section must be fully completed by hospital medical staff or records – any fee for completion of this section is the responsibility of the beneficiary of insurance

- a) Type of hospital/ward \_\_\_\_\_
- b) Name of Doctor or Consultant in charge \_\_\_\_\_
- c) The dates admitted and released Admitted: \_\_\_\_\_ Released: \_\_\_\_\_
- d) Was any period spent in Intensive Care Yes/No From: \_\_\_\_\_ To: \_\_\_\_\_
- e) Was the patient subsequently confined to their home on medical grounds? Yes/No  
If **Yes**, please give dates From: \_\_\_\_\_ To: \_\_\_\_\_
- Is there any additional information that you feel is relevant

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_  
Position held in Hospital: \_\_\_\_\_ Qualifications: \_\_\_\_\_

**Please use validation stamp or complete in block capitals:-**

Hospital Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone No: \_\_\_\_\_

Validation stamp
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Thank you for your assistance in completing this form.

## Doctor's statement

This section must be fully completed by attending doctor – any fee for completion of this section is the responsibility of the beneficiary of insurance

Patient's Name: (Mr, Mrs, Miss, Ms) \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Please give full details of injury/illness: \_\_\_\_\_

Final diagnosis: \_\_\_\_\_

When did the patient first receive medical attention for this condition? \_\_\_\_\_

Has the patient ever suffered with this or a any similar condition before the present episode? Yes:  No:

If **Yes**, please give details including dates treatment and consultation: \_\_\_\_\_

Are you the patient's usual Doctor: Yes:  No:

If **No** please give name and address of usual Doctor \_\_\_\_\_

On what date did incapacity commence? \_\_\_\_\_

Is patient still incapacitated? Yes:  No:

If **YES** when will patient be able to return to work? \_\_\_\_\_

If **NO** when did incapacity cease? \_\_\_\_\_

Was the patient hospitalised as a result of this condition? Yes:  No:

Is there any additional information that you feel is relevant?

**Signed**

**Name** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Position held in Hospital: \_\_\_\_\_ Qualifications: \_\_\_\_\_

**Please use validation stamp or complete in block capitals:-**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
TelephoneNo: \_\_\_\_\_

Validation stamp
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Thank you for your assistance in completing this form.

**Payee's bank details**

If we approve your claim, we can credit the money direct to your bank account. This method is quicker, safer and more reliable than payment by cheque. If you would like us to do this, please complete the following:-

Name of your Bank/Building Society:	Bank Sort Code						
_____	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>						
Address: _____	IBAN _____						
_____	BIC _____						
_____	Account Number _____						
_____ Postcode: _____	Name of Account Holder (s) _____						

**Data protection**

Protecting your privacy is very important to Chubb European Group Limited ("Chubb"). Any information that you or your medical representative provides in the claim form and/or Doctor's Statement is "sensitive data" as defined by the Data Protection Acts of 1988 and 2003. Sensitive data includes any information about your physical and mental health. We require your consent before we can process this or any other such sensitive data that you may have already provided us with or may do so in the future.

In order to administer your claim, this information will be used by Chubb and its group companies. It may be held in computer and or in manual files for administration, and risk assessment purposes. We may disclose your personal data and sensitive data to, and may request information from other insurance companies and private investigators for underwriting, claims handling and fraud prevention purposes.

By returning this form, you consent to our processing your sensitive personal data for the above purposes. You also consent to our transferring your information to countries which do not provide the same level of data protection as Ireland, if necessary for the above purposes. If we do make such a transfer we will, if appropriate put a contract in place to ensure your information is protected. Guidelines for sharing of information in this regard are contained in a Code of Practice on Data Protection for the Insurance Sector which has been approved by the Data Protection Commissioner.

Where you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

**Declaration**

I declare that all the information given is to the best of my knowledge and belief, full true and correct. I give permission for any Medical Practitioner, Law Enforcement Agency or Statutory/Regulatory Authority mentioned with respect to this claim, to release information regarding my records.

**Signed**

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

**Checklist**

Please return the completed claim form together with any enclosures to your insurance broker or to Chubb European Group Limited and please ensure:

- You fully complete every question **before** your doctor completes his statement
- You have enclosed all requested original documents (we recommend you retain copies)
- You have signed this claim form
- Your attending doctor fully completes the statement

If you do not complete all sections and provide all requested documentation your claim will be delayed.

**Chubb. Insured.<sup>SM</sup>**

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