



Personal Accident Claim Form

Accident & Sickness

This form should be completed as fully as possible in BLOCK CAPITALS and returned immediately to your Broker with supporting documents.

Please ensure that all relevant questions are answered, and that all appropriate sections and boxes are completed. Failure to do so may delay the processing of your claim.

The form when fully completed must be returned to your Insurance Broker, who arranged this insurance for you. They will forward it to BIBU.

Insurance Broker Details			
Name & Address			
Postcode		Tel. No.	
Contact Name		Email	

If the benefit is to be used for the provision of a replacement worker, please support with evidence of expenditure.

Sections A Insured Person Accident/ Sickness Details) & Section B (Access to Medical Records) to be completed by the Insured. Section C to be completed by the attending medical practitioner.

Section A: Insured Person Accident/Sickness Details *(To be completed by the claimant)*

If you are unable to complete this form personally, due to your disability, it may be completed on your behalf.

Policy No.	<input type="text"/>	Policyholders Name	<input type="text"/>
Insured Person's Name	<input type="text"/>		
Date of Birth	<input type="text"/>	Occupation(s)	<input type="text"/>
Address	<input type="text"/>		
Postcode	<input type="text"/>	Tel. No.	<input type="text"/>
		Mobile	<input type="text"/>

Please state your average gross weekly wage, calculated over the 12 months prior to the commencement of disability.

If you are claiming for Temporary Total or Temporary Partial Disablement, please provide payslips or copy accounts confirming details of your Gross Weekly wage for the 52-week period prior to the date of the accident or onset of the sickness.

Please state the date from which you have been unable to attend your normal occupation?

Have you ever suffered from this or any connected disability prior to the insurance commencing? Yes No

If 'yes' please provide full details, including dates.

Are you still **totally** incapacitated as a result of your accident/sickness? Yes No

If 'no' please provide the date that you were able to undertake

a) Part of your duties b) All of your duties

ACCIDENT - Date and time of Occurrence	SICKNESS - Date upon which symptoms first appeared
Please describe the circumstances leading to your accident	Please describe the nature of your sickness

Please provide the name and address of the Doctor who attended you.

Please provide the name and address of your usual Doctor (if different).

When did you first seek medical attention in relation to your disability?

During what period have you been confined to hospital? From To

What is your expected date of return to work?

Full name and address of employer at the commencement of disability.

Have you previously claimed personal accident/ sickness benefits under this insurance? Yes No

If Yes, please provide full details.

Are you covered for benefits for your disability under any other insurance? Yes No

If Yes, please provide full details.

DECLARATION

I/We understand that in handling this claim, BIBU (a trading name of Geo Underwriting Services Ltd) will act on behalf of the Insurer(s) and that **I/We** confirm our informed consent to the claim being handled on this basis. **I/We** understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution. **I/We** confirm that the information given on this form is to the best of my knowledge and belief, true in every respect and that I have declared and not claimed amounts refunded to me or claimed from any other source. **You must read the declaration before signing.**

Signed

Date

If you are not the insured person, please state your relationship to them.

SECTION B: Access to Medical Records ACT 1988

In accordance with the Act and before we can apply for a medical report from your doctor, we need your consent. Before signing in the space below, you should know that you have certain rights under the Access to Medical Records Act 1988.

These are set out below:

- (A) You can withhold your consent.
- (B) You can see the report before it is sent to us or during the six months after that.
- (C) You can ask the doctor if he will amend any part of the report, which you consider to be incorrect or misleading. If the doctor is not in agreement, you may append your comments.
- (D) The doctor can withhold from you the report, or part of it, if he/she thinks you would be harmed by seeing it.

CONSENT TO OBTAIN MEDICAL REPORT

Name of Insured Person:	Date of Birth:
Address:	Post Code:

I/We understand that in handling this claim, BIBU (a trading name of Geo Underwriting Services Limited) will act on behalf of the Insurer(s) and that I/We confirm our informed consent to the claim being handled on this basis. I/We understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution.

I/We confirm that the information given on this form is to the best of my knowledge and belief, true in every respect and that I have declared and not claimed amounts refunded to me or claimed from any other source. I have been informed of my statutory rights under the Access to Medical Records Act 1988. In connection with my insurance claim hereby consent to BIBU and/or AXA Insurance Ltd instructed to deal with this claim on their behalf, being provided with medical information from any doctor; who at any time, has attended me concerning anything which affects my physical or mental health. I agree that a copy of this consent shall have the validity of the original.

You must read the declaration before signing

I wish to see the report before it is sent to the company (please tick) Yes No

Signed Date

Name of Doctor:	
Address:	Post Code:

Section C: Medical Report *(To be completed by the attending medical practitioner)*

The claimant must obtain at his or her own expense the following Certificate from a qualified and Registered Medical Practitioner.

Are you the usual Medical Attendant of the claimant? Yes No

If Yes, how long have you been so?

On what date did you first attend upon claimant for his/her present disability?

From what date did you first sign the claimant as unfit for work?

Please confirm the nature of the sickness or injury sustained, together with details of the precise diagnosis and treatment being given

Has the claimant suffered from this or any other associated complaint, prior to this period of disability?

Yes No

If yes, please give the details and types of treatment.

Date	Treatment

At the time of the accident or commencement of sickness was the claimant suffering from any other sickness or disease?

Yes No

If 'Yes', please give details with medication prescribed and advise whether this will delay the recovery of this disability

Is the disability caused by or traceable to any gradually developing bodily deterioration?

Yes No

If Yes, please provide full details including original date of onset

Is the disability due to Human Immunodeficiency Virus (HIV) and/or any HIV related sickness, any psychiatric, mental or nervous disorder, mental sickness, anxiety, stress or depression, self inflicted injury, drug abuse, pregnancy or childbirth related conditions?

Yes No

If Yes, please provide details

When do you expect claimant to return partial duties?

When do you expect claimant to return full duties?

If the claimant has already returned to work please state the date and whether he/she was able to return to all, or just part of his/her duties

DECLARATION BY YOUR DOCTOR

I confirm that that the claimant is/was under medical attention, and was totally prevented from working for remuneration or profit from his/her normal occupation from _____ to _____

Doctor's Signature	Date
Doctor's Name (BLOCK CAPITALS)	

Doctor's Official Stamp



Important notice regarding claims payments

If your claim is successful you will receive a payment by BACS transfer. Please complete the below to speed up the payment process.

You may wish to submit this page separately to your Insurance Broker. If so, please ensure you provide your policy number and/ or claim reference number. Thank you.

Name of Bank	
Branch	
Sort Code	
Account Number	
Account Name	
Payment Reference	

If the account details provided above are for someone other than the named policyholder, please provide a comment in the box below, and authorisation:

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By providing your details below, you confirm that all parties of the insured entity agree that payment may be released to this account rather than to the account of the policyholder:

Policyholder Name	
Policyholder Signature	
Date	

Once the appropriate claim payment/s have been processed and the above details are no longer required, they will be removed from the claim file and destroyed in accordance with our data retention policy.

BIB, 2nd Floor, Pioneer House, Pioneer Court, Morton Palms, Darlington, DL1 4WD.
T: 0344 346 0251 Email: claims@bibinsurance.co.uk

BIBU is a trading name of Geo Underwriting Services Ltd. Registered in England No. 4070987. Registered Address: 1 Minster Court, Mincing Lane, London EC3R 7AA. Authorised and regulated by the Financial Conduct Authority. FCA Register Number 308400. A member of the Ardonagh Group of Companies. Telephone calls may be recorded. Insurers, their agents and fraud prevention agencies obtain and share information with each other to prevent and detect fraudulent claims. This helps to protect our customers and ourselves from such activity. In addition, we reserve the right to load your details to the Insurance Fraud Register which may affect your future applications for insurance products. For further information please visit the IFR website www.theifr.org.uk/en. For details of how we use personal information collected, view our privacy policy at www.geounderwriting.com/fair-processing-notice. V_03.20 Classified Public