ACE European Group
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Claim Form

PERSONAL ACCIDENT
Personal Accident Plan for Student *arranged by* Endsleigh Insurances (Brokers) Limited

PLEASE USE BLOCK CAPITAL LETTERS USING BLACK INK AND ENSURE YOU SIGN THE DECLARATION ON THIS FORM.
THANK YOU FOR NOTIFYING US OF YOUR CLAIM. PLEASE COMPLETE **ALL** QUESTIONS - IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE 'N/A'

NAME OF UNIVERSITY/COLLEGE YOU ATTEND	POLICY NO.
FULL NAME OF INSURED PERSON (MR/MRS/MISS/MS)	DATE OF BIRTH
FULL ADDRESS (PLEASE SPECIFY IF HOME OR TERM-TIME)	
	POSTCODE
TELEPHONE NO. BUSINESS	TELEPHONE NO. HOME
OCCUPATION: (STUDENT OR OTHER IF OTHER, PLEASE SPECIFY)	E-MAIL ADDRESS
FOR SECURITY PURPOSES PLEASE PROVIDE A PASSWORD WHICH WILL BE REQUIRED TO ACCESS YOUR CLAIM INFORMATION:	

ACCIDENT DETAILS

Please give exact date and time when injured: DATE _____ TIME _____ am / pm

Please state:-

(a) The date you ceased attending college: _____

(b) The date you returned to college: _____

(c) If you have not returned to college, on which date do you hope to do so? _____

Please state fully:-

(a) Where the accident occurred: _____

(b) How the accident occurred (Please state the sport being played): _____

(c) The injuries sustained: _____

- If you are claiming Temporary Total Disablement please state which part is applicable:
  - ☐ (a) Unable to attend any part of your studies
  - ☐ (b) Incurring extra expenses in travelling to and from college to continue studies (please note the only cover applicable for travelling to or from hospital is under Section 6, Additional Travelling Expenses, of the Platinum or Platinum Elite Policy)

  If (a) is applicable you must have a Medical Certificate veryfying the period you are unable to attend College.

  If (b) is applicable you must supply receipts and travel tickets to support the claim.
- If you are claiming for loss of earnings (Platinum Policy and Platinum Elite Policy), please enclose proof of earnings. ☐
- If you are claiming for Hospital Confinement please ensure the Hospital Statement is complete. ☐
- Emergency Travel Expenses : Please provide all relevant travel receipts ☐
- Dental Expenses : Please provide all relevant dental receipts ☐
- Physiotherapy following Broken Bones or Primary Dislocation : Please provide all physiotherapy receipts ☐
- Medical Certificate Expense : Please provide a receipt from your Doctor/GP ☐

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 INSURED PERSON (STUDENT)

(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:-

VALIDATION STAMP

Hospital Name: _____

Address: _____

_____

_____

Telephone No: _____

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 INSURED PERSON

Patient's Name: (Mr, Mrs, Miss, Ms) _____

Date of Birth: _____ Height: _____ Weight: _____

Please give full details of injury or if applicable details of Broken Bones or Primary Dislocation of Joint(s): _____

_____

_____

Final diagnosis: _____

_____

_____

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

Has the patient ever suffered with this or any similar injury 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/studies? _____

If NO when did incapacity cease? _____

Is there any additional information that you feel is relevant? _____

_____

SIGNED _____ DATE _____

Qualifications: _____

Please use validation stamp or complete in block capitals:-

VALIDATION STAMP

Name: _____

Address: _____

_____

_____

Telephone No: _____

Thank you for your assistance in completing this form.

ACCESS TO MEDICAL REPORTS ACT 1988 BEFORE YOUR ATTENDING DOCTOR CAN GIVE A MEDICAL REPORT ON THIS CLAIM FORM WHICH IS A REQUIREMENT OF THIS CLAIM, YOU MUST GIVE YOUR CONSENT. BEFORE GIVING YOUR CONSENT, YOU SHOULD BE AWARE OF YOUR RIGHTS UNDER THE ACT WHICH ARE SUMMARISED AS FOLLOWS:-

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of this report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the doctor to amend any part of the report which you consider to be incorrect or misleading. If the doctor does not agree with your request you may attach your comments to the report.

NB: The doctor may withhold all or part of the report from you if he considers that you may be physically or mentally harmed by it.

PATIENT DECLARATION

Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my claim

1. I hereby consent to ACE seeking medical information from any doctor who at any time has attended me concerning conditions which affect my physical or mental health.
2. ☐ I **DO** wish to see the report before it is sent to ACE
   ☐ I **DO NOT** wish to see the report before it is sent to ACE
3. I authorise such doctor to disclose such information to ACE.
4. I agree that a copy of this consent shall have the validity of the original.

SIGNED _____ DATE _____

DATA PROTECTION The information that you and your medical representative have provided in the claim form and Doctor's Statement is 'sensitive data' as defined by the Data Protection Act 1988. 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 ACE European Group Limited and its group companies. It may be held on 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 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 the UK, 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.

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.

SIGNED _____ DATE _____

CHECKLIST PLEASE ENSURE...

☐ YOU FULLY COMPLETE EVERY QUESTION **BEFORE** YOUR DOCTOR COMPLETES HIS STATEMENT

☐ YOU HAVE ENCLOSED ALL REQUESTED INFORMATION/DOCUMENTATION

☐ YOU HAVE SIGNED THIS CLAIM FORM .

☐ YOUR ATTENDING DOCTOR FULLY COMPLETES THE STATEMENT

AS FAILURE TO DO SO WILL RESULT IN DELAY IN HANDLING YOUR CLAIM

Please return the completed Claim Form together with any enclosures to:-
Endsleigh Insurance (Brokers) Limited, Hadley House, Shurdington Road, Cheltenham GL51 4UE

Thank you for fully completing this claim form.

MD/1062 Personal Accident Plan for Student 11/09