CLAIM FORM

Locum Scheme

ACE European Group
Claims Department
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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. IF YOU ARE CLAIMING FOR JURY SERVICE COVER YOU NEED NOT COMPLETE THE ACCIDENT/SICKNESS, DOCTOR'S STATEMENT OR ACCESS TO MEDICAL REPORTS SECTIONS.

Certificate/Policy no. or please enclose a copy of the certificate of insurance	For security purposes please provide a password which will be required to access your claim information:	
Name of Policyholder	Date of Birth	MALE / FEMALE
Full home address		
		Postcode
Telephone no. home	E-mail address	
Full practice address		
		Postcode
Telephone no. business	E-mail address	

Have you commenced or recommenced smoking since applying for this insurance? YES / NO

Do you practice at any other address or with any other partnership? YES / NO

If YES, please give details: ______________________________

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Do you qualify for the Primary Care Trust (PCT) Locum reimbursement? YES / NO

If YES, please state amount: ______________________________

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Has a Locum been appointed during your absence? YES / NO

If YES, please enclose documentation showing the weekly charges made to date.

insured.™

ACCIDENT / SICKNESS DETAILS

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 have not returned to work, on which date do you hope to do so? ______________________

If **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 ______________________

Have you ever suffered from this illness before? 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 or illness ______________________

JURY SERVICE

Details of jury service attendance: From: ______________ To: ______________ Total Days Served: ______________

Required documentation checklist:

- ☐ Certificate of Attendance from Jury Officer at the court
- ☐ Proof of you having engaged a Locum including dates of cover
- ☐ Copy of original summons letter
- ☐ Copy of your subsequent confirmation letter indicating the dates you were expecting to serve and confirming whether your attendance was deferred.
- ☐ Evidence to show all reasonable efforts were made to obtain a Locum, in the event that surgery cover was provided by a general medical practitioner within your own general medical practice. In this event all claims are subject to a 25% reduction in benefit.

GENERAL DETAILS

Please state your usual Doctor's name and address: ______________________

______________________ Postcode: ______________ Telephone No: ______________

Please state your usual Treating Consultant's name and address: ______________________

______________________ Postcode: ______________ Telephone No: ______________

Please provide medical certificates for your period of incapacity.

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/illness: ______________________________

____

____

Final diagnosis: ______________________________

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____

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

Has the patient ever suffered with this or 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 ______________________________

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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 DATE

Qualifications: ______________________________

Please use validation stamp or complete in block capitals:-

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

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*

Address ______________________________

____

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______________ Postcode ______________

Bank Sort Code (from the top right hand corner of your cheque)

Account Number ______________________________

Account Name(s) ______________________________

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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 1998. 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 return the completed claim form together with any enclosures to your insurance broker or to ACE 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

As failure to do so will result in delay in handling your claim.

Thank you for fully completing this claim form.

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