Canopius Underwriting Limited
Personal Accident and/or Sickness Insurance

Claims Form

Most delays in settling claims arise because claim forms are not fully completed or requested documents are not sent to us. We would therefore ask you to answer all questions fully and ensure all requested documentation is enclosed upon return of this claim form.

Important:

Please remember to read and sign the declaration, failure to sign the declaration will delay the assessment of your claim.

The Doctor's Medical Report must be completed and medical certificates submitted monthly so long as disablement continues.

Before having the Doctor's Medical Report completed please read and sign the Medical consent report form.

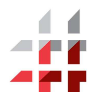
If you find you do not have sufficient room to answer any question in full or you think you have additional information you feel is pertinent to your claim please use additional paper remembering to sign and date each sheet. Please indicate the number of additional pages attached to the claim form below the declaration.

Please return the completed form to your Insurance Broker or the office detailed below.

Canopius Underwriting Limited
Gallery 9, One Lime Street
London EC3M 7HA

Tel. 020 7337 3700
Fax. 020 7337 3999

Canopius Underwriting Limited is an appointed representative of Canopius Managing Agents Limited which is authorised and regulated by the Financial Services Authority



CANOPIUS

Your Details

Certificate No.____________________

Certificate Period:____________________to____________________Sum Insured :____________________

Name of insured :____________________

Name of claimant :____________________Date of Birth :____________________

Address of Claimant :____________________Telephone No :____________________

Occupation : ____________________Fax No____________________

Gross Annual Salary :____________________Email Address : ____________________

Details of Accident / Sickness

Date of accident / appearance of symptoms____________________

Description of injury / sickness____________________

In case of accident, please describe how it happened____________________

Period of Accident / Sickness

Due solely to above mentioned accident/illness have you been unable to attend to any part of your business or occupation? YES / NO

If yes, are you still disabled Yes / No ,

Dates between which you have been continuously disabled: ____________________to ____________________both days inclusive

If you have been able to attend to any part of your business or occupation since the accident / illness, please give particulars including

dates____________________

____

Previous History

Have you any previous history of a similar injury? If so, please give full details:____________________

____

____

____

Medical Expenses

If you have coverage for medical expenses as a result of the above please supply full details of the expenses incurred together with bills and receipts.____________________

____

____

Other Insurances

Have you any other insurances under which this claim or part thereof may be recoverable?____________________

____

____

Medical Practitioner

Please supply the name and address of your usual Medical attendant.____

____

____

____

DECLARATION

I understand that the making of a fraudulent claim by providing information which is untrue is a criminal offence likely to lead to prosecution. I confirm that the information given on this form and information provided by myself on pages attached to this form is, to the best of my knowledge and belief, true in every respect and that the amounts claimed have not been refunded to me or claimed from any other source.

YOU MUST READ THE DECLARATION BEFORE SIGNING.
PLEASE READ AND SIGN THE ACCESS TO MEDICAL RECORDS CONSENT FORM OVERLEAF.

Signature:____________________________________ Date :____________________

Full Name_____________________________________

Please use additional paper if space provided on this form is insufficient; please attach additional paper when submitting this form.

Number of additional pages attached :___________________

MEDICAL REPORT

Claimant details:

Name of Claimant ____

Name of Patient if different from Claimant ______________________ Patients Date of Birth____________

Relationship to Claimant____

Doctor's Report:

Dear Doctor,
The above named person has submitted a claim under their Personal Accident / Sickness Insurance Policy. In order for us to assess the claim we would be grateful if you would answer the questions below. Please use additional paper if required and indicate the number of pages used below the declaration.

Name of person to whom this report refers (the patient) ______________________________

Are you the patient's usual practitioner? YES / NO

How long have you acted in this capacity?____________ Years.

What is the precise nature of the condition, illness or injury that has caused a claim to be made under this policy?

____

When were you first consulted about this condition? ______________________________

Has the patient suffered from the same or a similar condition in the past? YES / NO

If so please advise dates of all previous treatments ______________________________

Has the patient been included on a waiting list for in-patient treatment for this condition? YES / NO

If so please advise the date they were put on the list ______________________________

Is the patient suffering from any other condition which may affect the normal process of recovery? YES / NO

If so please give details :____

If the patient is not in full time employment please replace the word 'occupation' with 'usual day to day activities' where it appears in the following questions, and indicate here : The patient informs me he/she **is / is not** in full time employment

Has the patient been TOTALLY disabled from attending to ANY part of his/her business or occupation? YES / NO

If so please give date of commencement of TOTAL disablement :______________________________

When did or when do you expect the claimant to return to his/her occupation :

i)on a partial basis :____________________

ii) on a full time basis :____________________

DECLARATION

I have examined the patient and/or his medical records. I confirm that to the best of my knowledge the information given above is correct and that no details relevant to the case have been omitted.

Signed Practice stamp:

Name Date of signing:

Qualification
Number of additional pages attached :____________

MEDICAL REPORT CONSENT FORM

Name: ______________________________ Date of Birth: ______________________________

Address: ____

____

____

____

General Practitioner: ______________________________ Specialist: ______________________________

Address: ______________________________ Address: ______________________________

______________________________ ______________________________

______________________________ ______________________________

____

Telephone: ______________________________ Telephone: ______________________________

I hereby consent to a medical report or my records being supplied in confidence to the Insurers' Medical Adviser by the above named doctor or their nominated deputy. I understand that it may be necessary to discuss some of these matters in the strictest confidence with their personnel in order to process the claim underwriting decision.

I understand my rights under the Access to Medical Reports act 1988 and have read the summary of my principal rights under this act.

Delete where inapplicable

- I DO NOT wish to have access to the medical report or noted before they are supplied.
- I DO wish to have access to the medical report or notes before they are supplied and understand that I have 21 days in which to make the necessary arrangements with my medical practitioner, who is entitled to charge a fee for this service.
- I agree to be seen and examined by the Insurers Medical Adviser. I also understand that any information or opinions drawn from his examination of me may also be divulged to the Insurers (or agreed third parties) and also understand that this may be used in making underwriting and claims decisions.

A copy of this consent shall be valid as the original.

Signed: ______________________________ Date: ______________________________

ACCESS TO MEDICAL REPORTS 1988

This is a summary of your principal rights under the Act, which is concerned with reports provided for employment or insurance purposes by a medical practitioner who is, or has been, responsible for your care.

Option A. You may withhold your consent for the report from a medical practitioner.

Option B. You may consent to the application but indicate your wish to see the report before it is supplied. (You must make the necessary arrangements with the medical practitioner to see the report, it will not be sent to you automatically).

The medical practitioner will be informed that you wish to have access to the report and will allow 21 days for you to see and approve it before it is supplied to the applicant. If the medical practitioner has not heard from you in writing within 21 days of the application for the report being made, he/she will assume that you do not wish to see the report and that you consent to its being supplied.

When you see the report, if there is anything in it which you consider incorrect or misleading, you can request (but this request must be in writing) that the medical practitioner amend the report, but he/she is not obliged to do so. If the medical practitioner refuses to amend it, you may :

i) withdraw consent for the report to be issued.

ii) ask the medical practitioner to attach to the report a statement setting out your own views.

iii) agree to the report being unchanged.

NOTE: The medical practitioner is not obliged to show you any parts of the report which he/she believes might cause serious harm to your physical or mental health or that of others, or which would reveal information about a third party or the identity of a third party who has supplied the practitioner with information about your health, unless the third party also consents. In those circumstances the medical practitioner will so inform you and your access to the report will be appropriately limited.

Option C. You may consent to the application for the report, but indicate that you do not wish to see the report before it is supplied. Should you change your mind after the application is made, and notify the medical practitioner in writing, he/she should be allowed 21 days to elapse after such notification so that you may arrange to have access to the report (if the report has not already been supplied before you change your mind).

Option D. Whether or not you do decide to seek access to the report before it is supplied, you have the right to seek access to it from the medical practitioner at any time up to six months after it was supplied.

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.