ON DUTY ASSAULT BENEFIT CLAIM FORM

☐ **Serving Officer** ☐ **Police Staff**

This benefit is payable if an officer sustains Accidental Bodily Injury in the course of duty caused by:

- the discharge of either firearms crossbows or shotguns
  or
- stabbing inflicted by a knife, scissors, screwdriver or wood chisel or similar sharp instrument or as a result of an attack by a dog**

where, as a consequence of the injuries the officer is unable to continue pre-assault duties for a period of at least three consecutive days immediately after the attack

OR

- Burns causing permanent disfigurement or scarring

All claims will be paid in accordance with the policy terms, conditions and limits (see policy for full details)

****Benefit enhanced 1st October 2024 – for full details refer to policy**

Please complete this form and return it to: - Lincolnshire Police Federation, Police Headquarters, PO Box 999, Nettleham, Lincoln, LN5 7PH

Claimant details

Full Name:_____

Collar / Staff No: _____ Rank: _____

Date of Birth: _____ / _____ / _____

Home Address: _____

_____

_____Postcode:_____

Email Address: _____Tel No: _____

Claim details

Date of Incident: _____ / _____ / _____

Details of accident: _____

_____

_____

Assaulted with a firearm, knife or other (please specify): _____

_____

Suffering from: _____

_____

Absence Commenced: _____ / _____ / _____

Returned to duty on: _____ / _____ / _____

Total absence: _____ Days **(must be 3 consecutive days or more)**

Senior Officer Declaration

I declare that the above statements are true and complete.

Incident Reference: _____

Signed: _____ Date: _____

Name: _____

Rank: _____ Force Number: _____

Declaration

I declare that the information given on this form is true and complete to the best of my knowledge.

Signed: _____ Date: _____

I confirm that I have been informed of my rights under the Access to Medical Reports Act and consent to the underwriters to whom the claim is submitted (the underwriters) seeking medical information from any medical practitioner who has treated me or who has access to records relating to my physical and mental health, or any other source which is necessary and relevant in the opinion of the Underwriter's Chief Medical Officer.

Signed: _____ Date: _____

I do/do not* wish to see any medical reports prior to their release to the Insurer.
***Delete as applicable**

Signed: _____ Date: _____

I also consent to the release of such information to the Underwriter's Chief Medical Officer.

Signed: _____ Date: _____

I understand and consent to the use of this information provided on this form, together with medical and other information provided in connection with any claim, for the purposes of underwriting, administration, claim management, rehabilitation and customer concern handling. In order to do this, the information may be shared with other insurers, reinsurers, insurance intermediaries and service providers.

Signed: _____ Date: _____

BANK DETAILS

When your claim has been approved we will make the payment to you directly to your Bank Account.

Please complete the following: -

Name and address of your Bank:

_____

_____

_____

Branch Sort Code: _____/_____/_____

Account Number: _____

****Account Name(s): _____**

****Please ensure you provide us with the exact account name as it appears on your bank account. Failure to do so will result in a delay in us processing your payment.**

TO BE COMPLETED BY TRUSTEE OF SCHEME:

I certify that the claimant is a member of the Scheme and that the claim details are correct.

Date of Joining Scheme:- _____/_____/_____

Signed: _____ Date: _____

Name: _____

DATA PROTECTION NOTICE

Philip Williams (G Ins) Management Ltd collects and uses your data in accordance with current data protection law (which includes, from 25 May 2018, the General Data Protection Regulation (Regulation (EU) 2016/679)) ("data protection law"). We maintain records in regard to policy claims on computer and/or paper files. Information will only be disclosed to third parties in whatever format is considered appropriate by us. By signing this form, you consent to Philip Williams (G Ins) Management Ltd using your data and the information you have provided to process the claim. Further information can be found in our Privacy Policy at https://www.philipwilliams.co.uk

ACCESS TO MEDICAL REPORTS ACT 1988

Rights and Procedures

Access to Medical Reports Act 1988, Access to Personal Files and Medical Reports (Northern Ireland) Order 1991

We need your consent before we can approach any doctor for a medical report about you. This is given by signing the declaration on this form. Before you sign, you should read this section carefully. It details your rights under the Act.

1. You do not have to give your consent. If you do not give your consent, we may be unable to proceed with your claim.
2. You can request to see the report before it is sent to us. We will inform the doctor that you want to see the report before it is sent to us and confirm your request in writing. You will then have 21 days to arrange with the doctor to see the report. If you haven't arranged to see the report within this period the doctor will send it to us.
3. If you indicate that you don't want to see the report, we do not have to tell you if we apply for one. You can, however, ask to see a copy of the report within six months of it being sent to us.
4. The doctor may charge you a reasonable fee if you ask to see a copy of the report.
5. If you have seen the report before it is sent to us, the doctor will require your written consent to send it to us. You have the right to ask the doctor to change anything that you consider to be incorrect or misleading. The doctor can, however, refuse to make any alterations. If the doctor refuses to change the report you may attach a note giving your views.
6. The doctor can refuse to let you see all or part of the report if, in their opinion, it is likely to:

- Adversely affect your physical or mental health or that of others,
- Indicate the doctor's intentions to you,
- Reveal the identity of a third party who has given information about you unless they have consented to its disclosure or it has been supplied by a health professional involved in caring for you.

In such cases the doctor must notify you. You will only be able to see the remaining part of the report. If the whole report is affected the doctor will advise you and not send it to us without your written consent. If you refuse to give your consent we may be unable to proceed with your claim.

Privacy Notice

Please Note: Our Privacy Notice can be viewed on our website at www.philipwilliams.co.uk
A hard copy can be provided upon request.