PERSONAL ACCIDENT CLAIM FORM
PERMANENT TOTAL DISABILITY /
PERMANENT DISABLING INJURIES /
ACCIDENTAL LOSS OF USE /

To be completed by the Member for whom the benefit is being claimed and returned to Surrey Police Federation Office, Federation House, Highbury Drive, Leatherhead, Surrey, KT22 7UY or email to: admin@surrey.polfed.org
The issue of this form is in no way an admission to liability.

Claimant **Serving / Police Staff member * (*delete as appropriate)**

Full Name: _____

Date of Birth: _____ / _____ / _____

Division: _____ Rank: _____ Collar No: _____

Home Address: _____

_____

_____ Postcode: _____

Email Address: _____ Tel No: _____

Date of accident: _____/_____/_____ Time: ____:____ hrs Place: _____

Description of accident: _____

_____

_____

Name and addresses of witnesses: _____

_____

Nature of injury: _____

_____

Have you suffered a similar injury before? YES / NO* **(*delete as applicable)**

If yes please give details: _____

_____

Name & Address of the GP in attendance in respect of this injury: _____

_____Tel No: _____

Name & Address of your usual GP:_____

_____Tel No:_____

From what date were you: -

a) Totally disabled from attending your usual business or occupation? ____/____/____

b) Partially disabled from attending your usual business or occupation? ____/____/____

c) If still disabled when do you expect to resume your usual business or occupation? ____/____/____

Is your disablement solely due to the stated injury? YES / NO* **(*delete as applicable)**

If no please give full details: _____

_____

Were you suffering from any physical defects or infirmities prior to injury? YES / NO* **(*delete as applicable)**

Please give below details of any benefit to which may be entitled under any other insurance policy or club scheme with the name and address of the insurers or club:

_____

_____

BANK DETAILS:

When your payment has been approved we will make the payment to you directly to your bank account.

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 A TRUSTEE OF THE SCHEME:

I certify that the claimant is a member of the group insurance scheme and that the details are correct. I confirm that the member is covered under the scheme as indicated below:

Date of Joining Scheme: - _____/_____/_____ Date First Eligible to Join: - _____/_____/_____

Signed: _____ Date: _____

Please print name: _____

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: _____

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

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.

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.