PERSONAL ACCIDENT & ILLNESS CLAIM FORM

Claim Number: A claim number will be allocated once this form is returned

Claims Settlement Agencies Limited
308-314 London Road, Hadleigh, Benfleet, Essex SS7 2DD
Tel: 01702 842063 Fax: 01702 427173
email: aul@csal.co.uk www.csal.co.uk

AmTrust Underwriting
An AmTrust Financial Company

Please use the above address for ALL correspondence & quote the above Claim Number in ALL subsequent communication.
When the Claim Form is received we aim to process it in five working days. **Date:**
If original documents are being sent, we recommend sending via Recorded Delivery.
Please ensure you keep copies for your own records if posting original documents.

This claim form is being provided to you as requested in order that you can make a claim for Medical & Other Expenses under the terms and conditions of your travel insurance policy.

Below is a Document Check List – please ensure you provide the correct documentation when submitting your claim as failure to do so may cause delays.

We suggest you keep a copy of this claim form and other documents for your own records.

PLEASE ANSWER ALL QUESTIONS IN BLOCK CAPITALS – THANK YOU FOR YOUR CO-OPERATION

INSURED DETAILS

Q01. Insured Name:	Policy number:

CLAIMANT DETAILS

Q02. Claimant's details: Title:	First Name(s):	Surname:
Q03. Date of Birth:	Present Age:	
Q04. Address:		Post Code:
Q05. Home Tel:	Mob Tel:	Work Tel:
Email:		
Q06. Weekly Salary: ☐ Monthly Salary: ☐ Annual Salary: ☐	Gross:	Net:
Q07. Occupation in the Business:		
Q08. Relationship to Insured e.g. employee:		

DETAILS AND LOCATION OF ACCIDENT/ILLNESS

Q09. Details of Accident/Illness:

Q10. The date, time and place of Accident/Illness: Date:	Time: am: ☐ pm: ☐	Place:
Q11. Date incapacity from work commenced: Date:	When did it end? Date:	

Q12. Has the Claimant previously suffered from this or a similar medical complaint? **YES:** ☐ **NO:** ☐ If 'YES' please provide details:

Q13. How does the injury/illness preclude the Claimant from your occupational duties?

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DETAILS AND LOCATION OF ACCIDENT/ILLNESS continued…

Q14. Did the Claimant receive medical treatment? **YES:** ☐ **NO:** ☐

Q15. If 'YES' please provide details of the treatment and Doctors/Consultants attended?

MEDICAL CERTIFICATE - to be completed by the Claimant's usual GP at their own expense

Q16. Claimants name:	Q17. Condition suffered:
Q18. Date first unable to attend usual occupation:	Date will/predicted the claimant will return to work:
Q19. Total Disablement from usual occupation? **YES:** ☐ **NO:** ☐	Commencement date: To:
Q20. Partial Disablement from usual occupation? **YES:** ☐ **NO:** ☐	Commencement date: To:

Q21. Has the Claimant suffered previously from this condition or any similar condition? **YES:** ☐ **NO:** ☐ If 'YES' please provide details.

Signature of Qualification:	Date:
Name:	
Address:	Post Code:

ACCESS TO MEDICAL REPORTS ACT 1988

To enable us to consider your claim further we require a medical report from the Doctor you are consulting for this condition. To do this we require your consent, which you can indicate in the space below. Before doing so you should read the following statement that details your rights under the Access To Medical Reports Act 1988. You do not have to provide your consent to us being provided with a report but if you do you have the right to tell their doctor that you wish to see the report before it is sent to us. In this case the doctor cannot send it to us unless they have shown it to you or 21 days have passed without you having contacted your doctor about arranging to see the report.

Even if you do not initially ask to see the report before it is sent to us, the doctor must let you see a copy of the report for up to six months after it has been supplied to us, if you ask to see it.

Once you have reviewed the medical report, your doctor cannot submit it to us until they have your consent to do so. You can write to your doctor asking them to amend any part of the medical report if you consider it to be incorrect. Where you and your doctor are not in agreement with the content and the doctor is not willing to change their report you can attach a statement of your views that can be submitted with report.

In the event that the doctor believes that viewing some of the report would be detrimental to your physical or mental state. In this circumstance the doctor will notify you that you are viewing an edited version of the medical report. If the whole report is being withheld the doctor cannot send the report to us unless you give your express consent

CONSENT TO OBTAIN A MEDICAL REPORT TO BE COMPLETED BY THE PATIENT OR NEXT OF KIN (AS APPROPRIATE)

I have been informed of my Statutory Rights under the Access to Medical Reports Act 1988 (per the Claim Guidance Notes) and consent to Claims Settlement Agencies Limited obtaining a further medical report from a doctor who has cared for me should it be deemed necessary. In that event I do/do not wish to see (or have a copy of) the medical report before it is sent to Claims Settlement Agencies Limited.

I have been informed of my Statutory Rights under the Access to Medical Reports Act 1988 (per the Claim Guidance Notes) and consent to Claims Settlement Agencies Limited obtaining a further medical report from a doctor who has cared for me should it be deemed necessary. In that event I do/do not wish to see (or have a copy of) the medical report before it is sent to Claims Settlement Agencies Limited.

Patient Name:	Signature (Patient):	Date:
Doctor's Name:	Address:	

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SETTLEMENT DETAILS

Claims payments made by BACS transfer or other electronic banking system will be made and credited to your account.

By entering your bank account details, you confirm that CSAL has your full authority to remit monies directly to that account by the BACS or other electronic banking system. You also accept that, providing payment remitted to the bank account designated by you, CSAL shall have no further liability or responsibility in respect of such payment, and that it shall be your sole responsibility to make collection of any misdirected payment.

Name of account holder:	
Type of current account e.g. Platinum / Gold / Premier:	
Name and address of Bank / Building Society:	
Sort Code:	Account Number:

DATA PROTECTION NOTICE

Personal Information – means information that identifies and relates to you or other individuals (i.e. your dependants). By providing **Personal Information** to Claims Settlement Agencies you give us permission for its use as described below. Full details about our use of **Personal Information** can be found in our full Privacy Notice at www.csal.co.uk/privacy-policy or you may request a copy using the contact details above.

When providing **Personal Information** about another individual to us, you confirm that you are authorised to provide it for use as described below.

Types of Personal Information we may collect and why:
Depending on our relationship with you, **Personal Information** collected may include:

- identification and contact information,
- payment card and bank account,
- credit reference and scoring information,
- sensitive information about health or medical condition,
- and other **Personal Information** provided by you.

Personal Information may be used for the following purposes:

- Insurance administration, (communications, claims processing and payment)
- Decision-making on provision of insurance cover and payment plan eligibility,
- Assistance and advice on medical and travel matters,
- Management and audit of our business operations,
- Prevention, detection and investigation of crime, (fraud and money laundering)
- Establishment and defence of our legal rights,
- Legal and regulatory compliance, including compliance with laws outside your country of residence,
- Monitoring and recording of telephone calls for quality, training and security purposes.

Sharing of Personal Information:
Personal Information may be shared with our group companies, Brokers and other distribution parties, Insurers and Reinsurers, Credit Reference Agencies, healthcare professionals and other service providers. **Personal Information** may be shared with other third parties (including government authorities) if required by law. **Personal information** (including details of injuries) may be recorded on claims registers shared with other insurers. We are required to register all third party claims for compensation relating to bodily injury to workers' compensation boards. We may search these registers to detect and prevent fraud or to validate your claims history or that of any other person or property likely to be involved in the policy or claim.

Security and retention of Personal Information:
Appropriate legal and security measures are used to protect **Personal Information**. All third party service providers are also selected carefully and required to use appropriate protective measures. **Personal Information** will be retained for the period necessary to fulfil the purposes described above.

International transfer:
Due to the nature of our business, **Personal Information** may be transferred to parties located in other countries with different data protection laws than in your country of residence.

Data requests:
To request access or correct inaccurate **Personal Information**, or to request the deletion or suppression of **Personal Information**, or object to its use, please e-mail: info@csal.co.uk and mark for the attention of the Data Controller, or write to Data Controller, 308-314 London Road, Hadleigh, Benfleet, Essex SS7 2DD.

DECLARATION I declare that the whole of the statements made and any other supplementary statements forming part of this claim are true in every respect and understand that a false declaration may invalidate my claim and could result in prosecution. I give permission for my **Personal Information** to be used and shared in the ways described above. I confirm that I will not provide any **Personal Information** about another person without that person's permission.

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CUSTOMER DECLARATION – To Be Completed By ALL Persons Claiming Aged Over 16

Claims Settlement Agencies Ltd, agents and business partners may contact anyone who can give them information relevant to my claim. I/ We confirm that the information that I/ we give is true and if any of the information given by me/ us (or anyone on my/ our behalf) is incorrect, I/ we agree that such inaccuracy may cause me/ us to forfeit my/ our rights under the policy.
In the event of a Third Party being liable, on settlement of the claim I hereby subrogate my rights to the company to recover their costs.
Payments: Subject to admission of liability, we will make payment in favour of the claimant (aged over 16) as detailed in question 01 above but if an alternative payee is required please state below. I/ We have read and fully understood the above declaration.

Insured Name	Signature	Date of Birth	Date of Signature

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