

Claim form

Personal Accident/Sickness

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.

Policy number

Main Policy holder details

Title

First name

Last name

Email address

Date of Birth (DD/MM/YY)

Full address

Postcode

Contact no. (day)

Contact no. (eve)

For security purposes please provide a password which will be required to access your claim information

This is for additional security and you may be asked for it when calling Chubb.

Insured persons details

Full name

Date of Birth
(DD/MM/YY)

Relationship to
main policy holder

I intend to claim
on behalf of: (✓)
where applicable

Main Policyholder as above

Employment details

What is your occupation? _____

Please describe your duties: _____

Name & Address of employer: _____

Email address of employer: _____

Please state average annual gross and net salary over previous 12 months from the date of the incident (please enclose copies of 13 weeks payslips prior to the event) or over the previous 36 months from the date of a accident if self employed (please provide evidence of income by means of Inland Revenue Tax Assessment forms or audited accounts):

Gross: _____ Net: _____

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 haven't 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: _____

Has the patient ever suffered with this or any similar condition before the present episode? 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 _____

Hospital statement – only to be completed if claiming hospitalisation benefit

This section must be fully completed by hospital medical staff or records – any fee for completion of this section is the responsibility of the beneficiary of insurance

- a) Type of hospital/ward _____
- b) Name of Doctor or Consultant in charge _____
- c) The dates admitted and released Admitted: _____ Released: _____
- d) Was any period spent in Intensive Care Yes/No From: _____ To: _____
- e) Was the patient subsequently confined to their home on medical grounds? Yes/No
If **Yes**, please give dates From: _____ To: _____
Is there any additional information that you feel is relevant _____

Signed

Position held in Hospital: _____

Date

Qualifications: _____

Please use validation stamp or complete in block capitals:-

Hospital Name: _____

Address: _____

Telephone No: _____

Validation stamp

Thank you for your assistance in completing this form.

Doctor's statement

This section must be fully completed by attending doctor – any fee for completion of this section is the responsibility of the beneficiary of insurance

Patient's Name: (Mr, Mrs, Miss, Ms) _____

Date of Birth: _____ Height: _____ Weight: _____

Please give full details of injury/illness: _____

Final diagnosis: _____

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 _____

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

Name

Position held in Hospital: _____

Date:

Qualifications: _____

Please use validation stamp or complete in block capitals:-

Validation stamp

Name: _____	
Address: _____	
Telephone No: _____	

Thank you for your assistance in completing this form.

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 Sort Code						
Address: _____	<table border="1"> <tr> <td></td><td></td> <td></td><td></td> <td></td><td></td> </tr> </table>						
_____	IBAN _____						
_____	BIC _____						
_____	Account Number _____						
Postcode: _____	Name of Account Holder (s) _____						

Data protection

Protecting your privacy is very important to Chubb European Group Limited ("Chubb"). Any information that you or your medical representative provides in the claim form and/or Doctor's Statement is "sensitive data" as defined by the Data Protection Acts of 1988 and 2003. 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 Chubb and its group companies. It may be held in 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 and private investigators 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 Ireland, 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. Guidelines for sharing of information in this regard are contained in a Code of Practice on Data Protection for the Insurance Sector which has been approved by the Data Protection Commissioner.

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. I give permission for any Medical Practitioner, Law Enforcement Agency or Statutory/Regulatory Authority mentioned with respect to this claim, to release information regarding my records.

Signed

Name: _____	Date: _____
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Checklist

Please return the completed claim form together with any enclosures to your insurance broker or to Chubb 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

If you do not complete all sections and provide all requested documentation your claim will be delayed.

Chubb. Insured.SM

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