

Disability (accident or sickness) Claim form



Office Use Only	Policy reference	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Paymentshield
Claims Administration
PO Box 229, Southport
PR9 9WU

Tel: 0845 6011 060

Fax: 0845 6011 080

Disability (Accident or Sickness) Claim Form

Processing your Claim

To assist us in the processing of your claim we would ask that you read the claim form carefully and ensure all sections of the claim form are fully completed and that you forward all the information requested by us to avoid any delays.

Paymentshield endeavour to provide an excellent level of service and support during this difficult time. As such we undertake to deal with your claim as quickly and efficiently as possible as per the guidelines noted below.

- We will endeavour to process your claim and commence payment within 30 days of receipt wherever possible.
- We will confirm receipt of your claim within 5 working days. Where possible we will confirm if the claim has been approved or declined or we will detail any further information we require from you to progress your claim, based on the information provided at that time. We will also advise you of any third parties we have contacted in connection to your claim.
- Any correspondence we receive throughout your claim will be dealt with within 5 working days of receipt.
- If there is any information outstanding from yourself or a third party regarding your claim, we will endeavour to make contact with the relevant party every 14 days to try to obtain a response. We will also update you at this time on the status of your claim.
- If we are unable to obtain a response from a third party within 3 weeks of receiving your claim form we will endeavour to obtain a response from a different source. We may also request your assistance in obtaining the outstanding information. If we are unable to obtain the required information, it may result in the non-payment of your claim.
- On receipt of all relevant information, your claim will be passed for assessment and you will be informed of the outcome, in writing, within 4 working days.
- All payments relating to your claim will be processed by the Claims Team on the day of receipt of the correct evidence. Monies due will be released into your designated bank account within 3-7 working days of the payment being processed.
- Where you have requested a phone call we will endeavour to return your call by 12.00pm the following working day.

Section A - Guidance

The following notes detail which sections are relevant to your claim. Please read these carefully and complete all relevant sections.

- Section B** All applicants should read this section carefully.
- Section C** All applicants should complete this section.
- Section D** All applicants should complete this section and detail all people who can share information about your claim.
- Section E** All applicants should complete this section.
- Section F** All applicants should complete this section and it must be signed by all parties to the mortgage.
- Section G** All applicants should complete this section.
- Section H** This section should be completed in full by your employer (unless you were self-employed).
- Section I** Complete this section if your last work was on a self-employed basis.
- Section J** This section should be completed in full by your Doctor.
- Section K** All applicants should read this section carefully and sign the declaration.
- Section L** All applicants should complete this section.
- Section M** All applicants should read this section carefully and sign the declaration.
- Section N** Please use this section to give further information you think would be helpful in the processing of your claim.

Sharing your personal information

1. We are the insurance administrator for your policy, which is underwritten by Aviva Insurance Limited. Our details are: Paymentsshield Limited, company number 2728936 with our registered office at: Paymentsshield House, Southport Business Park, Wight Moss Way, Southport, PR8 4HQ. We are the DATA CONTROLLER for the purposes of the Data Protection Act.
2. Your personal information such as your name, address, date of birth, marital status, family details, employment details, financial details and medical details will be held by us on a database. The database is an electronic computerised database held on our computers at our office. We may also hold your personal information in a paper based filing system.
3. Your personal information includes all information about you held by us now or at any time in the future, and which comes from or relates to:
 - a) any application forms you send to us;
 - b) any other personal information you supply to us;
 - c) any insurance policies we supply to you;
 - d) any dealings you have with us in respect of claims and administration of claims;
 - e) any third parties who provide us with information about you.
4. We will use your information to:
 - a) deal with any claim you make on your insurance policy;
 - b) comply with compliance and regulatory requirements; and
 - c) to prevent and detect fraud we may at any time:
 - Share information about you with other organisations and public bodies including the police.
 - Undertake credit searches and additional fraud searches.
 - Check and/or file your details with fraud prevention agencies and databases and if you give us false or inaccurate information and we suspect fraud, we will record this.
 We can on request supply further details of the databases we access or contribute to.
5. We will pass your information to third parties in order to help us and help our insurance underwriters to make decisions on your claims.
6. Other than for the purposes outlined in paragraph 4 and 5 above, we will not pass your information to any other person, firm, company or organisation except:
 - a) if we have your consent;
 - b) if we are permitted or required to do so by law;
 - c) for the purpose of fraud prevention;
 - d) if we transfer our agreement with you or any insurance policy we hold for you to a third party.
7. If we pass your information to a third party we will ensure that anyone to whom we pass your information agrees to keep your information as secure as we keep it.
8. We will keep your information for as long as you hold an insurance policy through us and for a reasonable period thereafter.
9. You have the right to access copies of your personal information held on our database, and in our files by written letter sent to: The Data Protection Officer, Paymentsshield Ltd, PO Box 229, Southport PR9 9WU. The law allows us to charge you a fee for accessing copies of your personal information. This fee is £10 which you must pay before we send you the copies of your personal information.
10. If following the accessing of your personal information you find that personal information we hold about you is wrong, then please write to our Data Protection Officer whose address is at paragraph 9 above, and your personal information will be corrected.

Section C - Your details (To be completed by you)

Title	<input type="text"/>	Surname	<input type="text"/>				
Forename(s)	<input type="text"/>						
Address	<input type="text"/>						
		Postcode	<input type="text"/>				
Home Telephone Number	<input type="text"/>	Alternative Telephone Number	<input type="text"/>				
Email Address	<input type="text"/>						
Date of Birth	<input style="width: 20px;" type="text"/> /	<input style="width: 20px;" type="text"/> /	<input style="width: 20px;" type="text"/>	Age	<input type="text"/>		
National Insurance Number	<input type="text"/>						
Certificate Number	<input type="text"/>	Claim Number	<input type="text"/>				
Have you made any other claims in respect of this Disability?				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If Yes, please provide details	<input type="text"/>						
<input type="text"/>							
<input type="text"/>							
<input type="text"/>							
<input type="text"/>							

Section D - Sharing information about your claim (to be completed by you)

The details regarding your claim are considered to be private and cannot be disclosed to any other party without your express consent. This includes any other person named on the policy and any intermediary (e.g. financial advisor).

If we are asked to do so, can we share information about your claim with the intermediary who introduced your policy to Paymentsshield? Yes No

If Yes, please provide their full name and telephone number

If we are asked to do so, can we share information with any other person? Yes No

If Yes, please provide details of who we can share information with:

Name	<input type="text"/>	Relationship to you	<input type="text"/>
Name	<input type="text"/>	Relationship to you	<input type="text"/>
Name	<input type="text"/>	Relationship to you	<input type="text"/>

Medical Information: It is our company policy not to discuss any medical information with any other party under any circumstances.

Section E - Your financial details (to be completed by you)

Please note: we may request sight of pay slips for both insured parties (where appropriate) to support our assessment of your claim. This will allow us to determine the benefit amount applied to your particular claim.

Your annual income £

Current monthly mortgage repayment £ Current monthly buildings cover premium £

Current monthly contents cover premium £ Current monthly life cover premium £

Is your cover split with any other person? Yes No

If Yes, who is the cover split with?

Annual income of second named person £

Please provide your Bank Account details

Bank name

Bank Sort Code Branch

Account Number Name of account holder

Section F - Mortgage Details (To be completed by you)

Lender's Name

Lender's Address

Postcode

Mortgage Account Number Start Date of Mortgage

Is your Mortgage in joint names? Yes No

I/We are currently making a claim in respect of Disability. In order to process my/our claim Paymentsshield Limited will require information relating to my/our loan or mortgage agreement. I/We hereby authorise the release of this information without expense to Paymentsshield Limited or the insurer. Please also note my/our claim on your files.

A photocopy of this authorisation shall be considered as effective and valid as the original.

Signed (1) Signed (2)

Signed (3) Date

Section G - Disability & Employer's Details

Nature of Disability

Date disability began Date you last worked

Have you returned to work? Yes No

If yes, on what date? If no, on what date do you expect to return

Is your disability as a result of an accident? Yes No

If yes, give a brief description of the event

Employer's Name

Employer's Address

Postcode

Telephone Number

Staff Number

Occupation

Employment Terms (please tick appropriate box)

Permanent Full Time Part Time Fixed Term Contract Temporary Seasonal

Period of employment (from) Average hours worked per week

Section H - Employers statement (To be completed by your employer)

Please arrange for your employer to provide the following information.

Name of employee

Average hours worked per week What Class N.I. contributions were paid by the employee?

Employment Terms (please tick appropriate box)

Permanent Full Time Part Time Fixed Term Contract Temporary Seasonal

Period of employment (from) Date last worked (if applicable)

Dates unable to attend work due to accident or sickness?

From To

Date returned to work (if applicable)

Nature of sickness or injury

Has the employee previously suffered from this or any similar sickness or injury whilst working for you? Yes No

If Yes, please provide details and dates

Section H - Employers statement (continued)

Condition

From To

Condition

From To

Is the employee still working for you? Yes No

If No, please provide date and reasons for leaving Date

Please give details of the employees job title and job description or attach a copy

Signature Date

Position (to be completed by Line Manager/Personnel/Director/Owner)

Full Name

Name and Address of company

Postcode

Telephone Number

Fax Number

Contact E-mail Address

EMPLOYER'S STAMP

Section I - Self-employed statement (to be completed by you if self-employed)

Nature of business

Date trading commenced Date last worked

Date resumed work (if applicable)? Number of hours worked per week

Trading name and address

Postcode

Business telephone number Fax Number

Has the business ceased trading? Yes No

If No, please give details of how the business remains trading

Are you in receipt of any remuneration from the business? Yes No

Do you still participate in any way in the business? Yes No

If Yes, please give details

Your business accountant's name

Section I - Self-employed statement (continued)

Accountant's address

Postcode

Accountant's telephone number

Accountant's Fax Number

Address of Benefits Agency handling your claim

Postcode

Please provide proof of your payments of Class 2 National Insurance Contributions and a copy of your last self assessment tax calculation, received from the Inland Revenue.

Section J - Doctor's statement (To be completed by your doctor/surgery)

Please arrange for your doctor to provide the following information. Please note - if a fee is payable to your Doctor for the completion of this section, you will be responsible for paying this.

Patient's Full Name

Date of Birth

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From what date do you hold records for this patient?

From

--	--	--	--	--

Nature of accident/sickness (please note the condition not the procedure)

If accident, please state the cause

If the patient suffers from a back condition, has radiological evidence been obtained?

Yes

No

If Yes, please give details of the results i.e. was any abnormality detected

If the patient suffers from more than one condition, please list in order of severity indicating which condition renders the patient unfit for work:

a.

b.

c.

Date of first consultation with any UK based Doctor?

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First date of firm diagnosis of symptoms?

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First date patient certified unfit for work (for the present absence from work)?

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Has the patient previously consulted you or any doctor with symptoms of this or any similar condition?

Yes

No

If Yes, please give details including dates, diagnosis, cause, treatment and duration

Prior to the event leading to this claim, please give details of the dates you have seen (or were due to see) this patient for this condition

Has the patient been referred to a specialist?

Yes

No

If Yes, please confirm for which condition and the consultant's name and address

Postcode

Has the patient been admitted into hospital?

Yes

No

Please indicate the length of time the patient spent in hospital

From

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To

--	--	--	--	--

Is/are the condition(s) due or related to a self-inflicted injury, medical complication of pregnancy or childbirth, civil commotion or riot, or the consumption of alcohol, taking of drugs other than under medical advice?

Yes

No

If Yes, please provide further details in section N

Section J - Doctor's statement (continued)

Is/are the condition(s) due to failure to follow any medical advice? Yes No

If Yes, please provide further details in section N

If the nature of the sickness is related to a mental or nervous disorder (inc. depression, anxiety and stress) has the patient been referred to a third party for diagnosis and treatment? Yes No

If Yes, please provide further details in section N

Has the patient been certified fit to resume his/her occupation? Yes No

If Yes, please provide the date of certification

If No, when in your opinion will the patient be fit to resume his/her occupation?

I hereby certify this patient is/was receiving medical attention and is/was unfit to engage in their normal employment due to the condition(s) stated.

Doctor's name Doctor's address

Postcode

Doctor's signature

Date

Doctor's telephone number

Doctor's fax number

DOCTOR'S STAMP

Section K - Access to Medical Reports Act 1988 - Your rights under this Act - PLEASE READ

Access to Medical Reports Act 1988

Under the Terms and Conditions of the policy, we may ask the doctor or consultant who is caring for you to fill in a medical report so we can deal with your claim. To do this, we need your permission by signing the Access to Medical Reports Act 1988 (in Northern Ireland The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991) declaration contained on the proposal.

Before doing so, you should read this section carefully, as it sets out your rights under the Access to Medical Reports Act 1988 (in Northern Ireland The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991) in respect of the procedures for dealing with reports.

You do not have to give your permission to the Chief Medical Officer being given the report. However, under these circumstances, we may be unable to process your claim. If you give your permission, you have the right to tell your doctor (or consultant) that you wish to see the report before it is sent to us. In this case, your doctor (or consultant) cannot send it to us unless you have either seen the report or 21 days have passed without you contacting your doctor (or consultant) to arrange to view the report.

If at first you decide that you do not want to see the report but change your mind before your doctor (or consultant) sends us the report, you can tell your doctor (or consultant). You will then have 21 days to see the report.

We may not be able to go ahead with your claim without medical information. As a result, the sooner you act, the quicker we can consider your claim under this insurance.

Whether or not you ask to see the report before it is sent to us, your doctor (or consultant), if you ask, must let you see a copy for up to six months after they send it to us. If you ask for a copy of the report, your doctor (or consultant) may charge a reasonable fee to cover the cost.

If you see the report before it is sent to us, your doctor (or consultant) cannot send it to us until he or she has your permission. You can ask your doctor (or consultant) to change any part of the report and if they refuse, you can ask your doctor (or consultant) to send us a separate statement with the report giving the reasons why you consider it to be wrong or misleading.

Your doctor (or consultant) can refuse to let you see any part of the report that in his or her opinion would be likely to cause you or others any physical or mental harm. They can refuse if any part of the report may reveal information about another person unless that person gives permission or has cared for you in a professional way. In these cases, your doctor (or consultant) must tell you. You would be limited to seeing any remaining part of the report. If it is the whole report which is affected, your doctor (or consultant) must not send it to us unless you give your permission.

Access to Medical Reports Act 1988 Declaration

I have read and understood the above section in respect of My Statutory Rights under the Access to Medical Reports Act 1988 (in Northern Ireland The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991) in connection with my claim under this insurance policy. I consent to Paymentsshield Limited and Aviva Insurance Limited (or their agents) obtaining medical information from any Doctor who has attended me in respect of anything which affects my physical or mental health and I agree that a copy of this consent is valid as the original.

I wish to see the reports before they are sent to the company

I DO NOT wish to see the reports before they are sent to the company

Signature Date

Full Name in BLOCK CAPITALS

Q - How long will it take to process my claim?

A - We aim to process all claims wherever possible within 30 days of receipt of the claim form. There will be occasions when we may encounter delays as we await information from third parties. However, you can assist us in processing your claim as quickly as possible by fully completing the claim form and providing as much of the requested information as possible and returning it along with your claim form.

Q - Why do you need information from my employer?

A - In order for a claim to be met it is necessary to verify with your employer that you were actively working at the time your disability commenced and that your disability totally prevents you from working.

Q - I am self employed, what information do you require for me to evidence I was actively working at the time of my disability?

A - We will require copies of invoices, accounts or evidence of appointments etc from the time immediately before your claim occurred to show evidence that you were actively working.

Q - Why do you need information from me relating to my mortgage?

A - The policy you hold with Paymentsshield is a Mortgage Payment Protection Policy and we must ensure that a mortgage is held in your name on the property that you have insured with us and that the property is being used for residential purposes by you and your family.

Q - Why do I have to provide evidence of my income?

A - You are only able to insure a percentage of your income under the terms and conditions of your policy and we may request confirmation of your income to ascertain that your income fits within these guidelines.

Q - Why do I need to have the claim form completed by my Doctor?

A - We require verification of the condition that is preventing you from attending work. In addition it is necessary to confirm the dates of your initial consultation and the dates that you are unable to attend work in relation to your current period of absence and this must be independently confirmed by your Doctor or Consultant.

Q - What evidence do I need to provide each month in order to receive my monthly benefit payment?

A - We will require a sick note from your doctor covering your payment date each month to allow us to release your payment. Occasionally, we may request further evidence from your doctor during the claim period to enable us to continue releasing your benefit payments. Every 3 months we will require evidence from you in the form of a bank statement that your mortgage payments remain up to date. If we do not receive the information we request it could delay your monthly benefit payment or even stop us releasing your payment altogether.

Q - Why are you requesting my bank details?

A - Any benefit payments due relating to your claim will be made directly into your designated bank account.

