APPENDIX E

PERSONAL ACCIDENT CLAIM FORM

Completion Notes

1. If a claimant is unable to claim personally, the claim form may be completed on his/her behalf.
2. A claim must be submitted within a reasonable timeframe.
3. The claim **must**:
   a. Complete this page - ***in addition to*** the insurer's ***Incident Notification Advice Form*** (Appendix D)
   b. Be countersigned by the Instructor/Coach in charge of the training session at the time of the incident.
   c. Be sent by recorded delivery post to the BAB Insurance Liaison Officer, who is:

      Vincent Sumpter, 4 Connemara Close, Westbury, Wilts BA13 3FG
      (Tel: 01373 826910)
4. The BAB Claims Officer will forward the claim form to its Insurance Brokers, for their action.
5. Once the claim is received by Endsleigh, they will deal directly with you on any further action required in processing the claim. You may be required to provide documentation **at your own expense**. e.g. medical certificates.

Name:

Description of Incident: Date:

Name of Your Association:

Name of the Instructor:

Details of any Witnesses:

For your Instructor: I declare that this accident occurred as stated.

Signature of Instructor _____ Date _____

For use by the British Aikido Board:

Official Signature _____ Date _____

Personal Accident Claim Form

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.

Association: British Aikido Board	Certificate / Policy Number: UKBOPC53137
Member's Name:	Membership No:
Address: Postcode:	
Tel:	Mobile No:
Email	

Employment Details

Occupation:
Please describe your duties:
Name and address of employer
Email address of employer:

Accident Details

Please give exact date and time when injured: Date: Time: am / pm
Please state fully:

(a) Where the accident Occurred:

(b) How the accident occurred:

(c) The injuries sustained:

(d) Have you previously claim under this or similar policy? YES / NO

If yes please give details:

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 insured person.

(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: Date:

Position held in hospital: Qualifications:

Please use validation stamp or complete in block capitals:

Hospital Name:

Address:

Telephone No:

Thank you for completing this form.

Validation Stamp

Doctors Statement.

This section must be fully completed by attending doctor – any fee for completion of this section is the responsibility of the insured person.

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 conditions?_____

Has the patient ever suffered with this or any similar condition before? **YES / NO**

If yes, please give details including treatment and consultation:

_____
_____
_____

Are you the patients usual doctor? **YES / NO**

If no, please give the name and address of the usual doctor. _-

_____
_____

On what date did the incapacity commence?_____

Is the patient still incapacitated: **YES / NO**

If yes when will the 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: Date:

Qualifications:

Please use validation stamp or complete in block capitals:

Name:

Address:

Telephone No:

Validation Stamp

Thank you for completing this form.

Access to medical reports act 1988

Before your attending doctor can give a medical report on this claim form, which is a requirement of this claim, you must give your consent. Before giving your consent, you should be aware of your rights under the act which are summarised as follows:-

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of this report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the Doctor to amend any part of the report which you consider to be incorrect or misleading.

If the Doctor does not agree with your request you may attach your comments to the report.

NB: The Doctor may withhold all or part of the report from you if he considers that you may be physically or mentally harmed by it.

Patient Declaration

Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my claim

1. I hereby consent to ACE seeking medical information from any Doctor who at any time has attended me concerning conditions which affect my physical or mental health.

2. I **Do / Do Not *** wish to see the report before it is sent to the BAB's Insurance Brokers (* *delete as appropriate*)

3. I authorise such Doctor to disclose such information to the BAB's Insurance Brokers.

4. I agree that a copy of this consent shall have the validity of the original.

Signed: **Date:**

Data Protection

The information that you and your medical representative have provided in the claim form and Doctor's Statement is 'sensitive data' as defined by the Data Protection Act 1998. 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 the Insurer. It may be held on 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 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 the UK, 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. 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.

Patient Declaration

I declare that all the information given is to the best of my knowledge and belief, full true and correct.

Signed: **Date:**

Checklist

Please return the completed claim form together with any enclosures to your Insurance Broker 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