TEAM PERSONAL ACCIDENT BENEFITS CLAIM FORM

Please note that we have to ensure that our claim form covers all claims. If you do not consider a question to be relevant to your circumstances please enter N/A next to the question

It is important that you make sure you carefully read the declaration at the end of the claim form and ensure that it is signed before returning the form to us, failure to sign will result in your claim form being returned to you.

CLUB DETAILS

Full name of Club _____Policy Number_____

Contact address _____

_____Post Code_____

Contact Name_____ Position _____

Telephone Number_____Email address_____

CLAIMANT DETAILS

Full Name _____

Address _____

_____Post Code_____

Date of Birth _____Telephone number _____

Email address_____

EMPLOYMENT DETAILS

What is your occupation? _____

Are you: employed or self-employed? (Delete as appropriate)

Please provide a brief description of your duties_____

_____

If applicable, please provide the name and address of your employer_____

_____

_____Telephone Number _____

In order that your claim can be processed you will need to submit the following with your claim:-

- If employed – Wage slips for the 12 months preceding the date of the incident
- If self-employed – your last two Inland Revenue tax assessment forms or copies of your last two audited accounts.

PLEASE NOTE FAILURE TO SUPPLY THE ABOVE WILL DELAY YOUR CLAIM

ACCIDENT DETAILS

Date of Sports Accident _____Time of Sports Accident_____

Where did the Sports Accident occur? _____

_____

How did the accident occur? _____

_____

_____

What injuries did you sustain? _____

_____

_____

Did anyone witness the accident? YES /NO (delete as appropriate)

If yes please provide the full name(s) _____

Do you have any other insurance that may cover this injury? YES/ NO (delete as appropriate)

If YES please provide:

Name of Insurance Company: _____

Address of Company: _____

_____

Policy Number: _____

PAYMENT DETAILS

Should a payment become due under the insurance policy, your Insurers' preferred method of settlement is by BACS transfer and if this is convenient to you please complete the following:-

Account name:		Account number:	
Bank name:		Sort Code:	

Alternatively:

Please advise to whom any settlement cheque due should be made payable_____

DOCTOR'S REPORT

The claimant must at his or her own expense have the following certificate completed by their usual GP whom has full access to your complete medical history.

Full Name of Patient _____

Patient's Date of Birth _____

Are you the patient's usual practitioner? YES/NO how long have you acted in this capacity? _____Years

If 'No' please give the name & address of usual doctor _____

_____

Please give full details of the injury sustained? _____

_____

_____

Final diagnosis? _____

_____

When did the patient first receive medical attention for this injury? _____

_____

Has the patient ever suffered with this or any similar condition prior to this injury? YES/ NO

If 'Yes' please advise details and dates of all previous treatments _____

_____

_____

Has the patient been included on a waiting list for in-patient treatment for this condition? YES/ NO

If 'Yes'please advise the date they were put on the list _____

If the patient was admitted to hospital as a result of this injury please provide:-

Date & time of admission_____Date & time of discharge_____

Is the patient suffering from any other ongoing complaint that might hinder recovery? YES/ NO

If 'Yes' please give details: _____

Please give the dates the patient has been:-

Totally disabled from their usual business or occupation from_____to_____

Partially disabled from their usual business or occupation from_____to_____

If disability is ongoing please provide an indication as to when you feel that the patient may be able to return to work_____

If there is any additional information that you feel is relevant, please provide: _____

_____

_____

DECLARATION

I have examined the patient and/or his medical records. I confirm that to the best of my knowledge the information given above is correct and that no details relevant to the case have been omitted.

Signature_____

Name _____

Qualification(s) _____

Date_____

Practice validation Stamp: (Please include address & telephone number if not on stamp)

Thank you for your time and assistance in this matter.

ACCESS TO MEDICAL REPORTS 1988

This is a summary of your principal rights under the Act, which is concerned with reports provided for employment or insurance purposes by a medical practitioner who is, or has been, responsible for your care.

Option A. You may withhold your consent for the report from a medical practitioner.

Option B. You may consent to the application but indicate your wish to see the report before it is supplied. (You must make the necessary arrangements with the medical practitioner to see the report. It will not be sent to you automatically).

The medical practitioner will be informed that you wish to have access to the report and will allow 21 days for you to see and approve it before it is supplied to the applicant. If the medical practitioner has not heard from you in writing within 21 days of the application for the report being made, he/she will assume that you do not wish to see the report and that your consent to its being supplied.

When you see the report, if there is anything in it which you consider incorrect or misleading, you can request (but this request must be in writing) that the medical practitioner amend the report, but he/she is not obliged to do so. If the medical practitioner refuses to amend it, you may:

i) withdraw consent for the report to be issued

ii) ask the medical practitioner to attach to the report a statement setting our your own views.

iii) agree to the report being unchanged.

NOTE: The medical practitioner is not obliged to show you any parts of the report which he/she believes might cause serious harm to your physical or mental health or that of others, or which would reveal information about a third party or the identity of a third party who has supplied the practitioner with the information about your health, unless the third party also consents. In those circumstances the medical practitioner will inform you and your access to the report will be appropriately limited.

Option C. You may consent to the application for the report, but indicate that you do not wish to see the report before it is supplied. Should you change your mind after the application is made, and notify the medical practitioner in writing, he/she should be allowed 21 days to elapse after such notification so that you may arrange to have access to the report (if the report has not already been supplied before you change your mind).

Option D. Whether or not you do decide to seek access to the report before it is supplied, you have the right to seek access to it from the medical practitioner at any time up to six months after it was supplied.

Please note that where a copy of the medical report is supplied to you, the practitioner may charge a reasonable fee to cover the cost of supplying it.

MEDICAL CONSENT FORM

Full name of Patient_____

Date of Birth of Patient _____Address_____

_____

_____Postcode_____

General Practitioner _____

Address _____

_____Postcode_____

Specialist _____

Address _____

_____Postcode_____

I hereby authorise the provision of any information, including full health records, reports or notes concerning my health being supplied in confidence to AXA XL and third parties acting on their behalf to include CSA Ltd/Gallagher Bassett or their nominated deputy.

I consent to the above medical information and reports being:

- Used for the purposes of: claims handling; insurance administration; statistical analysis and fraud & crime prevention.
- Disclosed to: associated companies of MSIUL; third parties instructed by MSIUL for the purposes of claims handling; other parties to whom disclosure is necessary for the purposes of my claim or any reinsurance claim such as the insured, the insured's broker, MSIUL's co-insurers, MSUIL's reinsurer(s) and reinsurance broker; and regulatory bodies in connection with compliance with any regulatory rules or codes; and
- Transferred to any country, including those outside the European Economic Area, for any of these purposes.

I understand my rights under the Access to Medical Reports Act 1988 and have read the summary of my principal rights under this Act (please see overleaf).

Delete where inapplicable

I DO NOT wish to have access to the medical report or notes before they are supplied.

I DO wish to have access to the medical report or notes before they are supplied and understand that I have 21 days in which to make the necessary arrangements with my medical practitioner, who is entitled to charge a fee for this service.

A copy of this consent shall be valid as the original

Signature _____Date_____

Name (Block Capitals) _____

Data Protection

Please note that your personal information may be used for the purposes of insurance administration and claims handling by us, AXA XL, its associated companies, its co-insurers, the insured and its broker and other third parties advising us or otherwise relevant to the handling of your claim. Your personal information may be used by AXA XL and its reinsurer(s) and reinsurance broker(s) for any reinsurance claim made by them, for renewal purposes and for their management reporting and for internal and external audit.

It may also be used for statistical purposes, for fraud and crime prevention and may be disclosed to Lloyd's or regulatory bodies in connection with compliance with any regulatory rules or codes.

Your personal information may be transferred to any country, including those outside the European Economic Area, for any of these purposes.

DECLARATION

I understand that the making of a fraudulent claim or knowingly exaggerated claim or by providing untrue information is a criminal offence likely to lead to prosecution. I confirm that the information given on this form is, to the best of my knowledge and belief, true in every respect.

Claimant's signature_____ Date_____

Club Official's signature_____ Date_____

Position in Club_____

GUIDANCE NOTES

Please note that if you are unable to supply any of the evidence we request, you should include a separate covering note explaining this. This will enable us to deal with your claim promptly.

Thank you for completing this form.

Your claim form and supporting documents can be scanned and returned to us by email to Starpeak.Claims@csal.co.uk or by post to the following address:

CSA Ltd/Gallagher Bassett
48 Felaw Street
Ipswich
Suffolk
IP2 8PN

Should you require any assistance in the completion of this form or any query regarding your claim please do not hesitate to contact us by telephone on +44 (0)1702 427190.