BAB Personal Accident Claim Form 2024

Please complete the included

Chubb Claim Form and email it to our insurance officer at

insuranceofficer@bab.org.uk

Contact us for more information:

Chubb European Group Limited
Claims Department
PO Box 682
Winchester SO23 5AG
O +44 345 841 0059
F +44 141 285 2901
uk.claims@chubb.com

Claim form

This document contains fillable form fields.
It is recommended you **download** the file to fill in your information.

Data protection

We use personal information which you supply to us [or, where applicable, to your insurance broker] for underwriting, policy administration, claims management and other insurance purposes, as further described in our Master Privacy Policy, available here: https://www2.chubb.com/uk-en/footer/privacy-policy.aspx or by searching 'Master Privacy Policy' on https://www2.chubb.com/uk-en/. You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at dataprotectionoffice.europe@chubb.com.

Before completing this claim form you may prefer to submit your claim online, 24 hours a day, 7 days a week. It's easy to use and provides a contemporary claims experience for all customers www.chubbclaims.co.uk

Please write in black ink and use block capital letters.
- All relevant sections must be completed or marked 'not applicable'.
- Complete the checklist and ensure that you sign the declaration at the end of this form.

Name of Policyholder:

Certificate/Policy Number:

Insured details

Insured Person forename(s) (Mr/Mrs/Miss/Ms):

Insured Person sur

Full address:

Daytime Telephone Number:

Evening Telephone Number:

Postcode:

Date of birth:

Email Address:

1. Claim details

Did you suffer an injury or an illness? ☐ Injury ☐ Illness

Please give date, time and place where injured or taken ill:

Date / time:

Place:

Have you suffered from this injury/illness in the past? ☐ Yes ☐ No If 'Yes' please give details (including dates and any treatment):

Do you consider anyone to blame for the injury or illness? ☐ Yes ☐ No If 'Yes' please provide details:

Name of Insurer/Company/ Individual	Address/Contact Details	Any Reference Numbers

If you were injured, please state:

How the injury occurred:

The injuries sustained (please include details of any broken bones):

If you were ill, please state:

Full details of the illness:

2. Employment Details

What is your occupation?

As a result of the illness/injury, did you miss time at work? **If No, please proceed to section 3 Hospital Statement**

☐ Yes ☐ No

Name, address and telephone number of Employer:

Please describe the duties that you perform in your usual occupation:

Please provide your period of employment:

From: To:

The date you ceased working?

Have you returned to work? ☐ Yes ☐ No

If Yes, please confirm the date you returned to work:

If you have not returned to work, on which date do you hope to do so?

3. Hospital statement

Were you hospitalised as a result of your injury/illness? ☐ Yes ☐ No **If No, please proceed to section 4 Doctor's Statement**

This section must be fully completed by hospital medical staff or records department – any fee for completion of this section is the responsibility of the insured person:

Type of hospital/ward:

Name of Doctor or Consultant in charge:

The dates admitted and released:

Admitted: Released:

Was any period spent in intensive care: ☐ Yes ☐ No From: To:

Was any surgery required: ☐ Yes ☐ No If Yes, please provide a description of the surgery :

Was the patient subsequently confined to their home on medical grounds? ☐ Yes ☐ No If Yes, please gives dates:

From: To:

Is there any additional information that you feel is relevant?

Signed:

Dated:

Position held in Hospital:

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.

4. Doctor's statement

This section must be fully completed by your own doctor or doctor providing outpatient treatment' - any fee for completion of this section is the responsibility of the Insured Person.

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

Date of Birth:

Please give full details of injury/illness:

Final diagnosis: :

If you have fully completed these sections and require to add more detail, please continue on a separate piece of paper and attach to your claim form, providing your name and certificate/policy number.

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

☐ Yes ☐ No

When did the patient first receive medical attention for this condition?

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?

Was the patient hospitalised as a result of this condition?

If NO when did incapacity cease?

Is there any additional information that you feel is relevant?

Signed:

Dated:

Position held in Hospital:

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.

Access to Medical Reports Act 1988

Before your 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 Chubb 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 wish to see the report before it is sent to Chubb
   ☐ I do not wish to see the report before it is sent to Chubb
3. I authorise such Doctor to disclose such information to Chubb.
4. I agree that a copy of this consent shall have the validity of the original.

Signed:

Date:

Explicit Consent to use Health Information- Important Please Read

We carefully assess your claim, and also take steps, in common with standard industry practice, to monitor for fraudulent claims. For these reasons, we may need to use information about your health which is relevant to your claim, and, where relevant, the health of other persons relevant to the claim which you provide to us. ***You must ensure that any other persons whose information you provide to us understand and do not object to this use of their data, and (where required under applicable law) consent to us using their information for the purposes described here****.*

We will not use this health information for any other purpose, and will comply at all times with the terms (including security standards) referred in our Privacy Policy. You do not have to provide us with the following consent, and you may withdraw it at any time, but if you do not provide it, or choose to later withdraw it, that may affect our ability to process your claim.

Please tick the following box to indicate your consent to our use of your health information in this way*.* ☐

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

Address

Bank Sort Code

From the top right hand corner of your cheque

Account Number

Name of Account Holder(s)

Declaration

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

Signed: Date:

Checklist (reminder to provide, if applicable to your claim)

- ☐ Medical certificates
- ☐ Medical reports
- ☐ Hospital admission/discharge documents

Depending on your policy benefits, we may also ask for proof of income such as payslips, Tax Returns or audited accounts.

Please return the completed claim form together with any enclosures to your Insurance Broker or Chubb and please ensure:

- ☐ You have completed all relevant questions on this claim form
- ☐ You have enclosed all requested original documents (we recommend you retain copies)
- ☐ You have signed this claim form

Thank you for fully completing this claim form and enclosing all supporting documentation.

Chubb. Insured.℠