

# Personal Accident & Sickness Claim Form



**RURAL**  
INSURANCE

**IMPORTANT**

Please complete pages 1, 2 and 3 in full including the Access to Medical Reports Act section on page 5.  
Please ask your doctor / specialist to complete page 6.

**Personal Accident & Sickness Claim Form**

**INSURED**

Insured Name	<input type="text"/>	Policy No.	<input type="text"/>
Address	<input type="text"/>	Home Tel. No.	<input type="text"/>
		Work Tel. No.	<input type="text"/>
Main Occupation	<input type="text"/>	Mobile No.	<input type="text"/>
Other Occupations	<input type="text"/>	E-mail	<input type="text"/>

**CLAIMANT - (IF DIFFERENT FROM INSURED)**

Claimant Name	<input type="text"/>	Home Tel. No.	<input type="text"/>
Address	<input type="text"/>	Work Tel. No.	<input type="text"/>
		Mobile No.	<input type="text"/>
Main Occupation	<input type="text"/>	E-mail	<input type="text"/>
Other Occupations	<input type="text"/>		

## MEDICAL DETAILS

Please provide Name, Address and Telephone numbers of your attending GP and/or Specialist

	GP	SPECIALIST
Name		
Address		
Tel No.		

Under who's care are you now?

For how long have you been signed off (please enclose sick notes)

Do you hold any other insurance against accident or sickness?

Yes

No

If 'YES' please give details

Has the person insured made / making a claim or received compensation for this injury or sickness from any other insurance company?

Yes

No

If 'YES' please give details

## ACCIDENT ONLY CLAIMS

Date of Accident

Place of Accident

Circumstances of accident

What injuries did you sustain?

Did accident occur at work?

Yes

No

Were there any witnesses to the accident?

Yes

No

If 'YES' please give details

## SICKNESS ONLY CLAIMS

Date symptoms first appeared

Full details of nature of illness

Where were you when symptoms first appeared?

Have you ever suffered from this complaint before?

Yes

No

Is illness in any way work related?

Yes

No

If 'YES' please give details

## PAYMENT OF CLAIM

To avoid postal delays and the risk of theft we will pay any agreed amount due to you in respect of your claim directly into your bank account.

Please complete the following details about your bank account

Bank Name

Bank Account Number

--	--	--	--	--	--	--	--

Sort Code

--	--	--	--	--	--	--	--

Bank Account Name

If you would however prefer to receive a cheque please tick here

## DECLARATION

I/WE DECLARE THAT THE INFORMATION GIVEN ABOVE AND ON ANY ATTACHMENTS THERETO ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

**Signature of insured**

**Date**

**Signature of claimant  
(if not the Insured)**

**Date**

## ACCESS TO MEDICAL RECORDS ACT 1988 INSURANCE CLAIMS

In accordance with the Act and before we can apply for a medical report from your doctor, we need your consent. Before signing in the space below, you should know that you have certain rights under the Access to Medical Records Act 1988.

These are set out below:

- (a) You can withhold your consent.
- (b) You can see the report before it is sent to us or during the six months after that.
- (c) You can ask the doctor if he will amend any part of the report, which you consider to be incorrect or misleading. If the doctor is not in agreement, you may append your comments.
- (d) The doctor can withhold from you the report, or part of it, if he/she thinks you would be harmed by seeing it.

### CONSENT TO OBTAIN MEDICAL REPORT

Insured Name	<input type="text"/>
Address	<input type="text"/>
Postcode	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/>

I have been informed of my statutory rights under the Access to Medical Records Act 1988. In connection with my insurance claim hereby consent to Rural Insurance Group Ltd, being provided with medical information from any doctor; who at any time, has attended me concerning anything which affects my physical or mental health. I agree that a copy of this consent shall have the validity of the original.

I wish to see the report before it is sent to the company

Yes  No

**Signature**

**Date**

Name of Doctor	<input type="text"/>
Surgery Name	<input type="text"/>
Surgery Address	<input type="text"/>
Postcode	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Tel. No.	<input type="text"/>
E-mail	<input type="text"/>

## MEDICAL CERTIFICATE (To be completed at the expense of the claimant)

I CONFIRM THAT THE UNDERNOTED IS/WAS A PATIENT UNDER MY CARE AND THAT THE FOLLOWING DETAILS ARE CORRECT

Name of Patient

Date of Birth

Time/Date patient first consulted

Patients symptoms

Cause of symptoms

Treatment Given

Is there anything in the patients medical history which might have contributed to the occurrence or in any way retarded recovery?

Yes

No

If 'Yes' please give details:

How long is/was patient totally disabled from any work activities:

From

To

Dates shown to be inclusive

If total disability still continuing please advise probable date of resumption of:

1. Partial duties

2. Full duties

If patient now partially disabled please state:

1. From what date

2. Probable date of resumption of full duties

General Comments

## DECLARATION

I/WE CERTIFY THAT THE ABOVE DETAILS ARE TRUE AND CORRECT

Name

Qualifications

Address

Signature

Date





**Rural Insurance Group Limited**  
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**W [www.ruralinsurance.co.uk](http://www.ruralinsurance.co.uk)**

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