Rural
Insurance Group

Personal Accident & Sickness Claim

Rural Insurance Group Limited
The Hamlet
Hornbeam Park
Harrogate HG2 8RE

Tel: 0344 55 77 177 Fax: 01423 874127

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		Policy No.	
Address		Home Tel. No.	
		Work Tel. No.	
		Mobile No.	
Main Occupation		E-mail	
Other Occupations			

CLAIMANT - (IF DIFFERENT FROM INSURED)

Claimant Name		Home Tel. No.	
Address		Work Tel. No.	
		Mobile No.	
		E-mail	
Main Occupation			
Other Occupations			

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

Address

Postcode

Date of Birth / /

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

Surgery Name

Surgery Address

Postcode

Tel. No.

E-mail

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 occurence 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**

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