

Group Critical Illness

Member and Eligible Child Critical Illness details and consent form

This claim form should only be used when making a claim for an eligible child.

Section 1 should be completed by the member whose employer has provided the Critical Illness cover, whether or not they are the subject of the claim.

The child should then complete and sign Section 2 and Section 3 of this form.

However, if the child is under 16 years old or lacks the physical or mental capacity to complete the form, a person with legal parental responsibility for the child should complete Section 2 and Section 4 of this form.

If you have any question about completing this form or the details of the claim, you can email us at zcr.critical.illness.claims@uk.zurich.com or call us on 0800 181 4004 (option 3). Our lines are open Monday to Friday 9am to 5pm (except for bank holidays). We may record or monitor calls to improve our service.

Section 1

Member details

Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other (please give details below)
	<input type="text"/>
Surname	<input type="text"/>
Forename(s)	<input type="text"/>
Date of Birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Employer's name	<input type="text"/>
Employer's policy number (if known)	<input type="text"/>
Occupation	<input type="text"/>
Address	<input type="text"/>
Postcode	<input type="text"/>
Telephone number	<input type="text"/>
Mobile number	<input type="text"/>
Email address	<input type="text"/>

Preferred method of contact	<input type="checkbox"/> Email	<input type="checkbox"/> Text message	<input type="checkbox"/> Phone call
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Where you have selected 'text message', Zurich will provide you with updates on how your claim is progressing along with appointment reminders. We will not send any sensitive health information by text. You will be responsible for letting us know if your mobile number changes or if you'd like to opt-out of the service at anytime.

Please note there may be some circumstances where it may be necessary to contact you by another method.

Please tick if you would like us to contact you about our Critical Illness Support service:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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All valid critical illness claim payments will be made directly to you, the member, on behalf of the policyholder.

Please provide the details of your UK bank account where you'd like the claim payment to be made:

Bank name

Address

Account name

Sort code

Account number

Please complete this 'Confirming your identity' form **here** so we can verify your identity.

☐ I confirm that I have completed and will submit the 'Confirming your identity' form along with this form.

Failure to do so means we can't proceed with this claim.

All payments must be into a UK bank account held in the name of you, the member.

Member declaration

I have verified the accuracy and completeness of the information provided to Zurich by me in respect of the claim and confirm that, to the best of my knowledge and belief, all the information given is correct and that no material information has been withheld.

I understand that if the information or statements I have given about the claim or cover are incomplete, inaccurate or have not been updated if the information has changed, Zurich may not pay a claim, or if the information or statements I have given are untrue, the claim or cover may become void or be cancelled in accordance with Zurich's rights under the terms of the policy, in which case no cover or other benefits will be provided.

I have read the information relating to Data Protection and confirm that:

- I authorise you to process this claim and use the information I provide, and
- all the information passed to Zurich has been obtained in accordance with the data protection legislation requirements, including those relating to obtaining individual consents to processing.

I understand that I can withdraw my consent to Zurich using my personal data as detailed, however, I acknowledge this will affect Zurich's ability to administer the claim.

I understand that Zurich may contact the child or, where provided, the person with legal parental responsibility, in order to assess the claim in accordance with the Data Privacy Notice.

This form must be printed, signed, scanned and returned to us. If you would like to sign the form online using eSignatures, please contact our claims team by email or phone.

Member signature

Date

D	D	M	M	Y	Y	Y	Y
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Section 2

Information about the child (the subject of the claim) and consent to assess the claim

Where the child is over 16 years of age, this section should be completed and signed by them. If the child is under 16 years old or lacks the physical or mental capacity to complete the form, this should be completed and signed by a person with legal parental responsibility for the child.

Please provide copies of documentation confirming the child is an eligible child. This could be a birth certificate or other documentation confirming your relationship with the child.

☐ I confirm that I have provided relevant documentation to support the assessment that they are an eligible child.

Please complete this section of the form and provide copies of medical correspondence such as biopsy, histology and/or pathology results, hospital admission and discharge letters and copies of letters from the treating specialist, to allow the assessment of the claim.

Please confirm you have provided with this form all the supporting documentation you have for the assessment of this claim.

Yes

No

You can send all this information to us by email zcr.critical.illness.claims@uk.zurich.com or write to us at:

Zurich Corporate Risk
PO Box 3512
Swindon
SN3 9AH

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please give details below)

Surname

Forename(s)

Address (this should match the address on the medical record)

Date of birth

Relationship of the member to the child

If a person with legal parental responsibility is completing this part of the form, please provide their contact details below or tick 'Same as Member details provided in Section 1'.

Same as Member details in Section 1

☐ Yes

☐ No

Surname

Forename(s)

Date of birth

Address

Telephone number

Mobile number

Email

Preferred method of contact

Email

Text message

Phone call

Where you have selected 'text message' Zurich will provide you with updates on how your claim is progressing along with appointment reminders. We will not send any sensitive health information by text. You will be responsible for letting us know if your mobile number changes or if you'd like to opt-out of the service at anytime.

Please note there may be some circumstances where it may be necessary to contact you by another method.

Please select if you would like us to contact you about our Critical Illness Support service:

☐

Yes

☐

No

Basis of legal responsibility

If being completed by a person with legal parental responsibility, please confirm the relationship to the child

Which critical illness are you claiming for:

These are only headings, complete definitions can be found in the employer's policy terms.

Standard Critical Illness conditions:

- | | |
|---|---|
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Kidney failure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Major organ transplant |
| <input type="checkbox"/> Cancer – second and subsequent | <input type="checkbox"/> Motor neurone disease |
| <input type="checkbox"/> Cardiac arrest | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Coronary artery bypass grafts | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Creutzfeldt-Jakob disease | <input type="checkbox"/> Progressive supranuclear palsy |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart attack | |

Child Critical Illnesses:

- | | |
|---|--|
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Child Intensive care benefit | <input type="checkbox"/> Osteogenesis imperfecta |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Patau's syndrome |
| <input type="checkbox"/> Down's syndrome | <input type="checkbox"/> Permanent dependence |
| <input type="checkbox"/> Edward's syndrome | <input type="checkbox"/> Spina bifida |
| <input type="checkbox"/> Hydrocephalus | |

Additional Critical Illnesses (if covered by the policy and applicable to the member):

- | | |
|--|---|
| <input type="checkbox"/> Aorta graft surgery | <input type="checkbox"/> Liver failure |
| <input type="checkbox"/> Aplastic anaemia | <input type="checkbox"/> Loss of hand or foot |
| <input type="checkbox"/> Bacterial meningitis | <input type="checkbox"/> Loss of independent existence |
| <input type="checkbox"/> Balloon valvuloplasty | <input type="checkbox"/> Loss of speech |
| <input type="checkbox"/> Benign brain tumour | <input type="checkbox"/> Open heart surgery |
| <input type="checkbox"/> Benign spinal cord tumour | <input type="checkbox"/> Paralysis of limb |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Primary pulmonary hypertension |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Pulmonary artery graft surgery |
| <input type="checkbox"/> Chronic rheumatoid arthritis | <input type="checkbox"/> Respiratory failure |
| <input type="checkbox"/> Coma | <input type="checkbox"/> Terminal illness |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Third degree burns |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Heart valve replacement or repair | <input type="checkbox"/> Systemic lupus erythematosus (SLE) |
| <input type="checkbox"/> HIV | |

What symptoms were experienced that lead to you seek medical advice in relation to this critical illness?

Please use 'Other Information' section in this form if needed.

When did these symptoms start?

D	D	M	M	Y	Y	Y	Y
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What date was a medical practitioner first consulted with regards to this (please consider all consultations, including virtual GP discussions)

D	D	M	M	Y	Y	Y	Y
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Has a confirmed diagnosis been received that meets the critical illness definition being claimed for? (full definitions can be found in the employer's policy terms).

☐ Yes

☐ No

What date was this?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

What treatment has been or is currently being received in relation to this diagnosis?

Please use 'Other Information' section in this form if needed.

Has anything similar or related been experienced in the past?

☐ Yes

☐ No

Please provide full details

Please use 'Other Information' section in this form if needed.

Medical Practitioner details

General Practitioner

Name	<input type="text"/>
Practice name	<input type="text"/>
Address	<input type="text"/>
Telephone number	<input type="text"/>
Email address	<input type="text"/>

Specialist

Name	<input type="text"/>
Speciality	<input type="text"/>
Address	<input type="text"/>
Telephone number	<input type="text"/>
Hospital reference number	<input type="text"/>
Email address	<input type="text"/>
Date of appointment	<div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>
Please provide any additional information	<input type="text"/>

Section 3

Declaration of the child (where the child is 16 years or older)

Where the child is over 16 years of age this declaration should be signed by them.

I confirm the following:

I have read the explanation of my rights in the Access to Medical Reports notice below. I consent to Zurich seeking information in connection with the policyholder's claim in respect of me, including obtaining medical information from any medical practitioner I have consulted about my physical or mental health, so that Zurich may assess my state of health as part of their claims process.

I want access to any medical report prepared as a result, please state 'Yes'* or 'No' in the following box: Yes No

*Please note that by selecting 'Yes', this may delay Zurich's assessment of the claim by up to 21 days so you can view the medical report before it's released to Zurich.

I have read the 'Data Protection Statement' at the end of this form which explains how my personal information will be used and consent to my medical and health related data being used in the ways described.

I consent to Zurich obtaining information (including without limitation medical, occupational health) from third parties including but not limited to, the policyholder, the employer of the member (if different), the member, any occupational health provider, independent health professionals, brokers and professional advisers, other insurer(s) and reinsurer(s) in order to assess the claim and I authorise the giving of such information.

I understand the information obtained (including without limitation medical, occupational health) and any other information provided during the course of this claim, may where applicable be shared with relevant third parties, in order to assess and administer the claim, including without limitation the policyholder, the employer of the member (if different), the member, the person with legal parental responsibility (if different), other insurer(s), reinsurer(s) and relevant third party service providers such as treatment providers.

I consent to Zurich, and any companies it becomes associated with, using my information to:

- consider whether they are able pay a claim under the insurance policy
- respond to any complaints, or disputes in respect of the claim
- prevent or detect fraud
- manage risk and improve its services through anonymised data analysis, testing, research and statistical review
- meet their legal or regulatory obligations.

I hereby declare that to the best of my knowledge and belief, all the information given is true, complete and accurate and I have not withheld, and will not withhold, any material information.

I understand that if the information or statements I have given about the claim or cover are incomplete, inaccurate or have not been updated (if the information has changed), Zurich may not pay a claim, or if the information or statements I have given are untrue, the claim or cover may become void or be cancelled in accordance with Zurich's rights under the terms of the policy in which case no cover or other benefits will be provided.

I understand that Zurich may use my personal information to detect and prevent fraud and that this information may be shared, as necessary, with fraud prevention and detection agencies, including investigators.

I understand that Zurich will contact the member and/or the person with legal parental responsibility (if applicable) regarding the assessment of the claim.

I understand that I can withdraw my consent to Zurich using my personal data as detailed, however, I acknowledge this will affect Zurich's ability to administer the claim.

By signing below, I agree to the use of my personal information in the ways outlined in the 'Data Protection Statement' and as set out in this declaration and consent form.

This form must be printed, signed, scanned and returned to us. If you would like to sign the form online using eSignatures, please contact our claims team by email or phone.

Name:

Signature:

Date:

Section 4

Declaration and consent of the person with legal parental responsibility for the child

To be completed if the child is under 16 years or is otherwise not mentally or physically capable of completing the form.

I confirm for the information provided in respect of the child, that:

I have read the explanation of their rights in the Access to Medical Reports notice below. I consent to Zurich seeking information in connection with the policyholder's claim in respect of the child, including obtaining medical information from any medical practitioner consulted about their physical or mental health, so that Zurich may assess the state of the child's health as part of their claims process.

I want access to any medical report prepared as a result, please state 'Yes'* or 'No' in the following box: ☐ Yes ☐ No

*Please note that by selecting 'Yes', this may delay Zurich's assessment of the claim by up to 21 days so you (the person with legal parental responsibility) can view the medical report before it's released to Zurich.

I have read the 'Data Protection Statement' at the end of this form, which explains how the child's personal information will be used and consent to their medical and health related data being used in the ways described.

I consent to Zurich obtaining information (including without limitation medical, occupational health) from third parties including but not limited to the policyholder, the employer (of the member), independent health professionals, brokers and professional advisers, other insurer(s) and reinsurer(s) in order to assess the claim and I authorise the giving of such information.

I understand the information obtained (including without limitation medical, occupational health) and any other information provided during the course of this claim, may where applicable, be shared with relevant third parties, in order to assess and administer the claim, including without limitation the policyholder, the employer (of the member), other insurer(s), reinsurer(s), brokers and professional advisers, and relevant third party service providers.

I consent to Zurich, and any companies it becomes associated with, using my information to:

- consider whether they are able pay a claim under the insurance policy
- respond to any complaints, or disputes in respect of the claim
- prevent or detect fraud
- manage risk and improve their services through anonymised data analysis, testing, research and statistical review
- meet their legal or regulatory obligations.

I hereby declare that to the best of my knowledge and belief, all the information given is true, complete and accurate and I have not withheld, and will not withhold, any material information.

I understand that if the information or statements I have given about the claim or cover are incomplete, inaccurate or have not been updated (if the information has changed), Zurich may not pay a claim, or if the information or statements I have given are untrue, the claim or cover may become void or be cancelled in accordance with Zurich's rights under the terms of the policy in which case no cover or other benefits will be provided.

I understand that Zurich may use personal information to detect and prevent fraud and that this information may be shared, as necessary, with fraud prevention and detection agencies, including investigators.

I understand that I can withdraw my consent to Zurich using the child's personal data as detailed, however, I acknowledge this will affect Zurich's ability to administer the claim.

By signing below, I agree to the use of the personal information provided in the ways outlined in the 'Data Protection Statement' and as set out in this declaration and this section.

As the person signing with legal parental responsibility, I confirm that Zurich can use my data as detailed in this form to administer the claim.

I confirm I am completing this declaration on behalf of the child because the child:

☐ is under 16 years ☐ lacks mental capacity and/or physical capacity to complete the form

This form must be printed, signed, scanned and returned to us. If you would like to sign the form online using eSignatures, please contact our claims team by email or phone.

Name of the person signing
with legal parental responsibility:

Signature:

Date:

D	D	M	M	Y	Y	Y	Y
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☐ I confirm I have provided evidence of legal parental responsibility

Access to medical reports

If we apply to your doctor for a medical report, we will need your permission under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

Your medical report will provide information about:

- past and current health including relevant consultations, treatment, operations, investigations and test results that you may have undergone at any surgery, hospital, clinic, home visit or any that are pending
- details of any family history of disease that you have told your doctor about.

Your consent will give us access to this information. Your medical report will not ask about:

- negative tests for HIV, Hepatitis B or C
- incidences of sexually transmitted diseases unless there are long-term health implications
- predictive genetic test results unless there is a favourable test which shows you have not inherited a condition.

Data Protection Statement

Zurich takes the privacy and security of your personal information seriously. We collect, use and share your personal information so that we can provide policies and services that meet your insurance needs, in accordance with applicable data protection laws.

Where information has been provided in respect of a child, we will only use that information to:

- consider whether we are able pay a claim under the insurance policy
- respond to any complaints, or disputes in respect of the claim
- prevent or detect fraud
- manage risk and improve our services through anonymised data analysis, testing, research and statistical review
- meet our legal or regulatory obligations.

The type of personal information we will collect includes: basic personal information (i.e. name, address and date of birth), occupation and financial details, health and family information, claims and convictions information and where you have requested other individuals be included in the arrangement, personal information about those individuals.

We and our selected third parties, except for information relating to a child, will only collect and use personal information:

- (i) where the processing is necessary in connection with providing a quotation and/or contract of insurance;
- (ii) to meet our legal or regulatory obligations;
- (iii) where you have provided the appropriate consent;
- (iv) for our 'legitimate interests'.

It is in our legitimate interests to collect personal information as it provides us with the information we need to provide our services more effectively, including providing information about our products and services. We will always ensure that we keep the amount of information collected and the extent of any processing to the absolute minimum to meet this legitimate interest.

A full copy of our data protection statement can be viewed [here](#). This includes a specific section which applies to the child which is titled '**Child Data Protection Statement for Group Critical Illness claims**'.

Please let us know if you would like a copy of this in large print, braille or audio.

