# Group Critical Illness

## Member and Eligible Partner Critical Illness details and consent form

This claim form should only be used to make a claim for a member or their spouse or partner. Section 1 should be completed by the member (the employee) whose employer has provided the critical illness cover, irrespective of whether or not they are the subject of the claim.

The subject of the claim will then need to complete and sign section 2 of this form.

Please note - any claims paid will be paid to the member, or otherwise in accordance with the policy terms, on behalf of the policyholder.

If you have any question about completing this form or the details of the claim, please email us at **zcr.critical.illness.claims@uk.zurich.com** or call us on 08001814004 (option 3). Our lines are open Monday to Friday 9am – 5pm (except for bank holidays). We may record or monitor calls to improve our service.

### Section 1

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

Surname

Forename(s)

Date of Birth D D M M Y Y Y Y

Employer's name

Employer's policy number (if known)

Occupation

Address

Postcode

Telephone number

Mobile number

Email address

Preferred method of contact ☐ Email ☐ Text message ☐ Phone call

Please tick if you would like us to contact you about our Critical Illness Support service: ☐ Yes ☐ No

All valid critical illness claim payments will be made directly to you the member on behalf of the policyholder. Claims for the Cancer Drug Fund Benefit will be paid to the relevant NHS trust.

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 '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 the insured 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 that 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 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,
- 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.

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 |

## Section 2

### Information about the subject of the claim and consent

**This section should be completed by the person who has suffered the covered critical illness:**

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 your treating specialist, to allow the assessment of the claim.

Please confirm that you have provided, with this form, all the supporting documentation that you have for the assessment of this claim. ☐ Yes ☐ No

Who is the subject of the claim? ☐ Member ☐ Eligible partner

You can send 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
UK

**If the claim is for an Eligible Partner, this section must be completed.**

| | |
|---|---|
| Title | |
| Surname | |
| Forename | |
| Address (this should match the address on your medical record) | |
| Date of birth | D D M M Y Y Y Y |
| Telephone number | |
| Mobile number | |
| Email | |
| Preferred method of contact | ☐ Email ☐ Text message ☐ Phone call |
| Relationship to the member | |

**Which critical illness are you claiming for:**

(Please note, these are only headings. Complete definitions can be found in the employer's policy terms.)

**Standard Critical Illness conditions:**

- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Cancer – second and subsequent
- ☐ Cardiac arrest
- ☐ Coronary artery bypass grafts
- ☐ Creutzfeldt-Jakob disease
- ☐ Dementia
- ☐ Heart attack
- ☐ Kidney failure
- ☐ Major organ transplant
- ☐ Motor neurone disease
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Progressive supranuclear palsy
- ☐ Stroke

Additional Critical Illnesses (if covered by the policy):

- ☐ Aorta graft surgery
- ☐ Aplastic anaemia
- ☐ Bacterial meningitis
- ☐ Balloon valvuloplasty
- ☐ Benign brain tumour
- ☐ Benign spinal cord tumor
- ☐ Blindness
- ☐ Cardiomyopathy
- ☐ Chronic Rheumatoid arthritis
- ☐ Coma
- ☐ Deafness
- ☐ Encephalitis
- ☐ Heart valve replacement or repair
- ☐ HIV
- ☐ Liver failure
- ☐ Loss of hand or foot
- ☐ Loss of independent
- ☐ Paralysis of limb
- ☐ Primary pulmonary hypertension
- ☐ Pulmonary artery graft surgery
- ☐ Respiratory failure
- ☐ Terminal illness
- ☐ Third degree burns
- ☐ Traumatic brain injury
- ☐ Open heart surgery
- ☐ Systemic lupus erythematosus (SLE)

## Total Permanent Disability

☐ Total Permanent Disability (if covered by the policy) – we'll be in touch to find out more about this claim.

What symptoms did you experience that lead to you seek medical advice in relation to this critical illness?

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

When did these symptoms start? D D M M Y Y Y Y

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

Have you received a confirmed diagnosis that meets the critical illness definition you are claiming for? (full definitions can be found in your employer's policy terms and conditions) ☐ Yes ☐ No

What date was this? D D M M Y Y Y Y

What treatment are you currently receiving or have you received in relation to this diagnosis?

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

Have you experienced anything similar or related in the past? ☐ Yes ☐ No

Please provide full details

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

## Cancer Drug Fund

I confirm that I have received payment for a claim under this policy for:

- Cancer – excluding less advanced cases, or
- Cancer – second and subsequent.

☐ Yes ☐ No

I confirm that:

- my NHS specialist's submission for the provision of cancer drugs has been rejected by the local commissioning body on financial grounds, and
- a treatment plan has been agreed by the NHS multi-disciplinary team (MDT).

☐ Yes ☐ No

Please note, we will only be able to pay benefit for drugs recommended by an NHS specialist for cancer treatment that are:

- proven or established within common UK practice, such as a drug used within the terms of its licence, or approved by NICE for use in the NHS, and
- supported by the published, peer-reviewed clinical evidence that proves the treatment has positive clinical outcomes, and
- recognised as acceptable clinical practice and practiced widely by UK Specialists.

## Medical Practitioner details

**General Practitioner**

Name

Practice name

Address

Telephone number

Email address

**Specialist**

Name

Speciality

Address

Telephone number

Hospital reference number

Email address

Date of appointment D D M M Y Y Y Y

Please provide any additional information

## Subject of the claim declaration

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' 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 member (if not the subject of the claim), the policyholder, my employer (if different), occupational health providers, 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.

## Subject of the claim declaration (continued)

- 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 member (if not the subject of the claim), the policyholder, my employer (if different), other insurer(s), reinsurer(s), brokers and professional advisers, 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 to 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 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.
- With your permission, Zurich can offer a text (SMS) service to provide you with updates on how your claim is progressing along with appointment reminders. We will not send any sensitive health information by text. If you agree, you will be responsible for letting us know if your mobile number changes and you can opt-out of the service at any time.
- I agree that the Zurich Claims Team can contact me by mobile text messaging with appointment reminders and updates

Please select either 'Yes' or 'No' in the following box: ☐ Yes ☐ No

Please provide the mobile number

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.

Signature:

Date: D D M M Y Y Y Y

Print name

## 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.

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 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 that 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**.

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

Zurich Assurance Ltd.
Registered in England and Wales under company number 02456671.
Registered Office: Unity Place, 1 Carfax Close, Swindon, SN1 1AP.

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