Accident cash plan

Claim form

This claim form should be completed by or on behalf of the Policyholder and the person claiming (if other than the Policyholder).

Please return this form to Technical Referral Team, Zurich Insurance, 3000B Parkway, Whiteley, Fareham, PO15 7JZ.

1 Policy number

Policy number

Claims reference

2 Details of the Policyholder

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other (please specify)

Forename(s)

Surname

Address

Postcode

Daytime telephone number

Date of birth D D M M Y Y Y Y

Occupation

3 Details of person claiming if other than the Policyholder

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other (please specify)

Forename(s)

Surname

Address

Postcode

Daytime telephone number

Date of birth D D M M Y Y Y Y

Occupation

Relationship to the Policyholder

4 Details of the injury

Date of accident D D M M Y Y Y Y Time

Place

How it happened and injuries sustained (please continue on a separate sheet if necessary).

Police details (if involved)

Officer Reference no.

Address

Postcode

Employer's details (if it happened at work)

Name of first aid officer

Address

Postcode

Was the accident recorded in your employer's accident book? ☐ Yes ☐ No

5 General

Are/were you confined to hospital? ☐ Yes ☐ No

If Yes, please include discharge form showing dates or provide dates:

From D D M M Y Y Y Y To D D M M Y Y Y Y

Are you disabled from attending any occupation? ☐ Yes ☐ No

Are you insured against accidents with any other company? ☐ Yes ☐ No

If Yes, please give details (please continue on a separate sheet if necessary).

For office use only

Date form issued D D M M Y Y Y Y Date form returned D D M M Y Y Y Y

6 Claims data protection statement

This notice is important and should be read by the person making the claim. Please ensure that this notice is brought to their attention. In this notice the words "you", "your" and "yours" refer to the person making the claim.

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 via **www.zurich.co.uk/dataprotection**

How you can contact us

If you have any questions or queries about how we use your data, or require a paper copy of the statement, you can contact us via gbz.general.data.protection@uk.zurich.com or alternatively contact our Data Protection Officer at Zurich Insurance, Unity Place, 1 Carfax Close, Swindon, SN1 1AP.

Access to Medical Reports Act 1988

Your legal rights are:

- You don't have to give your consent, but if you don't we may not be able to consider your claim.
- You can ask to see the report before your doctor returns it to us. If you do, we will ask your doctor to retain it for 21 days so that you can arrange to see the report.
- You can ask your doctor for a copy of the report at any time during the six months after it has been sent to us.
- You can ask your doctor to amend the report if you consider any aspect of the report to be incorrect or misleading. If your doctor refuses to make the amendments, you may add your comments to the report.
- Your doctor may refuse access to medical records or part of them if, (in his or her opinion), this is detrimental to your health, would reveal information about somebody else or reveal the identity of a third party.

Consent to obtain a medical report

I have been informed of my statutory rights under the Access to Medical Reports Act 1988 which gives details of my rights of access to medical reports and records. I authorise those asked for information to provide it even though it may be confidential.

☐ I do not wish to have access to any medical report prepared as a result.

☐ I do wish to have access to any medical report prepared as a result.

Zurich may use a copy of this consent, which is valid for the duration of the claim, as an original.

Claimant's signature

Declaration

I/We understand that you may seek information from other Insurers to check the answers I/we have provided and declare that to the best of my/our knowledge and belief, all the information I/we have given is correct.

Signature of Policyholder

Date D D M M Y Y Y Y

Signature of person claiming if different from above

Date D D M M Y Y Y Y

Please ask your GP or consultant to complete the medical certificate section of this form. Please note that this is to be furnished at the expense of the person claiming.

Medical certificate – to be completed by a medical professional

This is to certify that

sustained a on

and was/is in hospital from date D D M M Y Y Y Y time

to date D D M M Y Y Y Y time

and was/is confined to home on medical advice from date D D M M Y Y Y Y time

to date D D M M Y Y Y Y time

Has the insured suffered from any similar or related complaint prior to the date of this incident? ☐ Yes ☐ No

If Yes, please give details (please continue on a separate sheet if necessary).

Is this previous condition contributing either directly or indirectly to the insured's current disablement? ☐ Yes ☐ No

If Yes, please state to what extent (please continue on a separate sheet if necessary).

Please state the possible duration of disability

Has the insured been referred to a Consultant? ☐ Yes ☐ No

If Yes, please provide the name and address.

Name

Address

Postcode

Your name

Address

Postcode

Signature

Date D D M M Y Y Y Y

Qualifications

Doctor's stamp

For office use only

Date form issued D D M M Y Y Y Y

Date form returned D D M M Y Y Y Y

ZPW81.07 (NP723419007) (08/23) CMS

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