INSTRUCTIONS - PLEASE READ CAREFULLY

Please ensure all questions are answered, if any are not applicable please indicate.

Section 1 – To be completed by you
Please ensure that both pages of this section are fully completed and signed by you.

Section 2 – To be completed by your GP (Doctor)
Ask your GP (doctor) to complete, sign and stamp section 2. Please note, any fee charged by your GP (doctor) will be your responsibility.

Section 3 – To be completed by your employer
If you were employed please ask your employer to complete this section. It must be fully completed, signed and stamped.

Section 4 – To be completed by your accountant (only if self-employed)
If you were self-employed please ask your accountant to complete this section. It must be fully completed, signed and stamped.

Section 5/6 – To be completed by you
If you have any further relevant information, please complete the 'additional information' section.

Please return this form enclosing all relevant documentation to:-

Claims Cog Limited,
4th Floor, Telecom House,
125-135 Preston Rd, Brighton and Hove,
BN1 6AF

**SECTION 1: PERSONAL DETAILS To be completed by you	
Policy number	
National insurance number	
Title	
First name	
Surname	
Date of birth	
Address	
Postcode	
Correspondence address (If different)	
Home telephone number	
Mobile telephone number	
Email address	
Bank account number	
Branch sort code	
Name of account holder(s)	
Bank name	
Have you ever claimed under this policy, or any other accident, sickness or unemployment policy? (If yes, please provide details including claim numbers)	Yes ☐ No

SECTION 1: PERSONAL DETAILS To be completed by you	
Are you claiming with another insurer or on any other insurance policies for this accident / sickness? (If yes, please provide details including policy schedules)	**Yes** □ **No**

ABOUT YOUR EMPLOYMENT	
Occupation	
Day last worked	
At the start of your Accident / Sickness, were you (please tick)	□ **Employed** □ **Self-employed** □ **Contract worker**
Employer name	
Address	
Postcode	
Telephone number	
Dates employed	Start date: End date:

DETAILS OF ACCIDENT / SICKNESS	
Date Accident / Sickness commenced	
Nature of Accident / Sickness	
How does the Accident / Sickness prevent you from working?	
Please advise how and when your Accident / Sickness started	
Doctor's Name	
Doctor's Address and Postcode	
Doctor's Tel. Number**	

Access to Medical Reports Act 1988

Summary of the main points contained in the Act.

The provisions noted in the Act above became effective from 1st January 1989 and before we can now apply for a medical report from your doctor we not only need your consent but must offer you the right to see the report before it is sent to us. There are a number of rights under this Act of which you should be aware and these are set out below as follows:

1. You may withhold your consent.

2. You have the right to see the report before it is sent to us provided you apply to the doctor within 21 days, or during the 6 months after that. The doctor may charge you a fee for supplying the report.

3. You can ask the doctor to amend any part of the report which you consider to be incorrect or misleading and if the doctor does not agree you may append your comments.

4. The doctor can withhold part or all the report from you if they have reasons why they think you should not see it.

Details of Your Rights

As, under the terms of your policy, we require completion of a medical report by the doctor who is caring for you to enable us to deal with your claim, we need your consent by completing the Consent Section of this form in full. Before doing so, however, you should read this note carefully as it sets out your rights under the Access to Medical Reports Act 1988 and the procedure for dealing with reports. You do not have to give your consent to Claims Cog Limited being provided with the report but, if you do, you have the right to tell the doctor that you wish to see the report before it is sent to us, in which case the doctor cannot send it to us unless either he has shown it to you, or 21 days have passed without your having contacted your doctor about arrangements to see it. Of course the quicker you act, the quicker your claim can be considered and we may not be able to proceed with your claim in the absence of medical information.

Whether or not you say you wish to see the report before it is sent to us, the doctor must let you see a copy for up to six months after it is supplied, if you ask. The doctor can charge you a reasonable fee to cover his costs.

Once you have seen a report before it has been sent to us, the doctor cannot submit it until he has your consent. You can write to the doctor asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your views on any part where you and the doctor are not in agreement and which the doctor is not prepared to alter.

The doctor is not obliged to let you see any part of a report that, in his opinion, would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the doctor's intentions towards you, or if disclosure would be likely to reveal information about, or the identity of, another person who has supplied information about you unless that person has consented or the information relates to, or has been supplied by, a health professional involved in caring for you. In such cases, the doctor must notify you and you will be limited to seeing any remaining part of the report, if it is the whole report which is affected, he must not send it to us unless you give your consent.

Sensitive Data

Information defined as sensitive within the Data Protection Act 1998 includes health records. The use of such sensitive data is required to enable your claim to be processed. Such information will only be held and used by Claims Cog Limited and their agents.

*Please return the attached form to us, please do not supply this directly to the surgery.

CLAIMS REFERENCE:

GP Details

Please give details of the doctor with whom you are currently registered.

Doctor's Name:	
Surgery Address:	
Postcode:	**Telephone:**

Your Consent:

I, the undersigned, have read the explanation of my rights under the Access to Medical Reports Act 1988 (see next page), and consent to ClaimsCog Ltd seeking information in connection with this claim from any doctor who has at any time attended me concerning anything which affects my physical or mental health, including a copy of my medical notes and consultant reports. I agree that a copy of this consent shall have the validity of the original, and I authorise the giving of such information.

**I do not require to see any medical report before it is issued.

Please delete the above sentence if you wish to see the report before it is sent to us.

You authorise ClaimsCog Limited to request your medical information from your registered GP Practice, using medical evidence gathering service, Medidata Exchange Limited trading as Medi2Data, working on our behalf.

Signature:
Full Name/s:
Date:**

**SECTION 2: TO BE COMPLETED BY YOUR GP (DOCTOR)				
Where more than one answer is available please circle the most appropriate				
Name of patient				
Nature of Accident / Sickness				
How does this prevent them from working?				
What medication / treatment has been prescribed?				
Have they been referred to a specialist? □ **Yes** □ **No** **If yes, on what date?**_____/_____/_____				
If yes, please provide specialist details	**Name**			
	Address			
	Postcode			
	Tel. No.			
Has the patient suffered from this or any associated complaint in the THREE YEARS prior to this episode?	□ **Yes** □ **No** **If yes, please provide details and dates of consultation:**			
Is the Accident / Sickness:	**Intentionally self-inflicted?**	Yes	No	
	Drugs/Alcohol related?	Yes	No	
	Due to a medical condition of Pregnancy?	Yes	No	
	Stress related?	Yes	No	

SECTION 2: TO BE COMPLETED BY YOUR GP (DOCTOR)	
Is the condition that your patient has is suffering, related to stress or anxiety that manifests itself as a physical condition?	□ **Yes** □ **No** **If yes, please provide details:**
If back condition, is this due to a medical abnormality or disease?	□ **Yes** □ **No** **If yes, please provide details:**
Is there radiological imagery?	□ **Yes** □ **No** **If yes, date of x-ray / scan:** _____/_____/_____
Was an abornormality detected?	□ **Yes** □ **No** **If yes, please state nature:**
When did the patient originally consult a doctor in relation to their current condition?	_____/_____/_____
When was the condition diagnosed?	_____/_____/_____
When did the symptoms first begin?	
Has the patient been certified as unfit to work, by way of medical certificates?	□ **Yes** □ **No** **If yes, from what date:** _____/_____/_____

SECTION 2: TO BE COMPLETED BY YOUR GP (DOCTOR)		
Has the patient returned to work?		□ **Yes** □ **No** **If yes, from what date:** _____/_____/_____
If the patient has not returned to work, please state:	When their current medical certificate expires:	_____/_____/_____
	Their estimated likely return date:	_____/_____/_____

GP's Signature: _____

Name (please print): _____

Telephone Number: _____

Date: _____

GP's Address Stamp

SECTION 3: EMPLOYER'S STATEMENT TO BE COMPLETED BY EMPLOYER		
Where more than one answer is available please circle the most appropriate		
Employee's name		
Job title		
Full description of duties		
Dates of employment	**From:**	**To:**
Does the employee work full-time over 16 hours per week?	**□ Yes □ No** **If no, on average how many hours?**	
Type of employment (please tick) **□ Permanent □ Fixed term □ Temporary □ Seasonal □ Government Training** **□ Apprenticeship □ Annually Renewable**		
Their employment status (please tick) **□ PAYE □ Self-employed □ Sub-contract**		
If employed on a sub-contract basis, is income tax deducted at source?	**□ Yes □ No**	
Is the employee on a fixed term contract?	**□ Yes □ No** **If yes, please give dates:** **From:_____/____/_____** **To:_____/____/_____**	
Is the employee currently on sick leave?	**□ Yes □ No** **If yes, from what date:** **_____/____/_____**	

SECTION 3: EMPLOYER'S STATEMENT TO BE COMPLETED BY EMPLOYER	
Did they become ill at work?	□ **Yes** □ **No** **If yes, please provide details:**
On what date did they become ill at work?	____/____/_____
On what date did they last attend work prior to this disability?	____/____/_____
Have they worked at all since this date?	□ **Yes** □ **No** **If yes, on what dates?**
Do they remain employed by your company?	□ **Yes** □ **No** **If no, please state date ended:** ____/____/_____ **And the reason:**
Have they now returned to work full time?	□ **Yes** □ **No** **If yes, on what date?** ____/____/_____
Have you been receiving regular medical certificates?	□ **Yes** □ **No** **If no, is there a reason?**

SECTION 3: EMPLOYER'S STATEMENT TO BE COMPLETED BY EMPLOYER	
Please provide dates of absences caused by illness in the past 18 months and advise the nature of the illness	

Thank you for taking the time to complete this questionnaire. Please sign, date and stamp the form below:

Employer's Signature: _____

Full Name (please print): _____

Your position with the company: _____

Telephone number: _____

Date: _____

Company Stamp

SECTION 4: SELF-EMPLOYED TO BE COMPLETED BY ACCOUNTANT (IF YOU DO NOT HAVE AN ACCOUNTANT PLEASE COMPLETE YOURSELF)	
Name of client	
Trading name	
Trading website (if applicable)	
Tax reference number	
Is your client liable for tax under Schedule D?	□ **Yes** □ **No** **If no, please state the reason:**
Is your client paying class II national insurance contributions?	□ **Yes** □ **No** **If no, please state the reason:**
Nature of business	
Did they work over 16 hours per week?	□ **Yes** □ **No** **If no, on average how many?**
Did your client own his or her own business?	□ **Yes** □ **No**
Were they employed as a sub-contractor?	□ **Yes** □ **No** **If yes, was income tax deducted at source? Yes** □ **No** □
Date self-employment commenced	
Has the self-employment been continuous to date	□ **Yes** □ **No**
Date above client last worked	

SECTION 4: SELF-EMPLOYED TO BE COMPLETED BY ACCOUNTANT (IF YOU DO NOT HAVE AN ACCOUNTANT PLEASE COMPLETE YOURSELF)

Please ensure that a copy of the following documentation is included with this claim form:

- **A copy of the last 3 years trading accounts;**
- **A copy of the last tax assessment;**

If you cannot provide any of the above documentation please advise why:

Accountant's signature	
Print name	
Date	
Telephone number	
Company stamp	

SECTION 5: FURTHER INFORMATION

Where more than one answer is available please circle the most appropriate:	
Do you have a Directorship to any business	□ **Yes** □ **No**
Are you registered with or associated to any other Company / Business, either Ltd on Non Ltd?	□ **Yes** □ **No**
If yes, please give details	
Please confirm the address of your/the business: **(And the registration number if applicable)**	
Please confirm the period that the business has been running from this address:	

CLAIM FORM APPLICATION - CHECK LIST

- **Section 1 – To be completed by you**
- **Section 2 – To be completed by your GP(Doctor)**
- **Section 3 – To be completed by your employer**
- **Section 4 – To be completed by your accountant (only if self-employed)**
- **Section 5 / 6 – To be completed by you****

It would also be helpful if you provided copies of your sick notes to confirm the dates you have been certified as unfit to work by your doctor.

SECTION 6: DECLARATION TO BE SIGNED BY YOU

I wish to claim under the terms of the policy and declare that to the best of my knowledge and belief I am eligible to do so, that the answers set out in this form are true and complete and I agree that any benefit payments made as a result of a known incorrect statement by me shall be repayable. I authorise my employer(s), the Employment Service/Benefits Office, The Inland Revenue/Tax Office, any Insurance office, my intermediary and my lender to provide Claims Cog Limited with any information relevant to this claim if required. I understand a representative of Claims Cog Limited may call for additional information. A copy of this authorisation shall be as effective and valid as the original.

Insurers and their agents share information with each other to prevent fraudulent claims via a Register of claims. A list of participants and the name and address of the operator of the Register are available on request. I understand that Claims Cog Limited may search the Register and that any information that I have supplied previously, the information I supply on this form and any other information relating to a claim, will be provided to the participants. I consent to Claims Cog Limited seeking any information, which it considers appropriate in connection with this claim, and authorise the giving of such information. In addition insurers, lenders and their agents may share information I have provided to them and may also undertake checks against publicly available information as necessary. I understand that you may seek information from other insurers to check the answers I have provided.

In order that my claim may be dealt with as speedily as possible, I consent that Claims Cog Limited may;

- Obtain any information, which they consider appropriate to my Protection Insurance claim including sensitive and personal information

- Contact my Finance House to discuss the terms ofmy Credit Agreement and to obtain any further information they deem necessary to process my claim

- Provide information or discuss all matters relating to my Protection Insurance claim, which may include Personal or Sensitive Data defined under the Data Protection Act 1998, and the General Data Protection Regulation (GDPR) with my Finance House or Supplying Dealer (if applicable)

Print Name: ..... Signature: .....
Date: .....

Note: We may obtain independent confirmation of information given in this claim form. Whilst the vast majority of claimants complete their claim honestly and truthfully a small number do deliberately make false declarations. If we become aware that a person has wilfully made any false declarations we do reserve the right to refer the matter to the appropriate authorities.

Please check you have included all requested information. Any information you are in doubt about should be disclosed. All additional documentation should be included where possible, but please do not delay in sending your form in.

FAILURE TO COMPLETE THIS FORM MAY RESULT IN A DELAY IN PROCESSING YOUR CLAIM

ADDITIONAL INFORMATION

Please return this form to:-

Claims Cog Limited, 4th Floor Telecom House
125-135 Preston Rd, Brighton and Hove,
Brighton, BN1 6AF

Data Protection and Privacy

We, Claims Cog Limited, are the data controllers (as defined by the Data Protection Act 1998 and all applicable laws which replace or amend it, including the General Data Protection Regulation) who may collect and process your personal information.

For full details of what data we collect about you, how we use this, who we share this with, how long we keep it, and your rights relating to your personal data, please refer to our Privacy Notice.

If you do not have access to the Internet, please write to the Group Data Protection Officer at the address listed below, with your address and a copy will be sent to you in the post.

In summary:

We, Claims Cog may, as part of our agreement with you under this contract, collect personal information about you, including:

- Name, address, contact details, date of birth and cover required
- Financial information such as bank details
- Details of any claim

We will also collect personal information about any additional people who you wish to be insured under the policy.

We, may also collect sensitive personal information about you, and any additional people who you wish to be insured under the policy, where the provision of this type of information is in the substantial public interest, including:

- Medical records to validate a claim should you be claiming for sickness or an accident.

We, collect and process your sensitive personal information for the purpose of insurance and claims administration.

All phone calls may be monitored and recorded and the recordings used for fraud prevention and detection, training and quality control purposes.

Your personal information may be shared with third parties which supply services to us or which process information on our behalf (for example, premium collection and claims validation, or for communication purposes related to your cover). We will ensure that they keep your information secure and do not use it for purposes other than those that we have specified in our Privacy Notice.

Some third parties that process your data on our behalf may do so outside of the European Economic Area ("EEA"). This transfer and processing is protected by EU Model Contracts which aim to provide the equivalent level of data protection to that found in the EU.

We will keep your personal information only for as long as is necessary to fulfil the purposes for which the personal information was collected (including for the purpose of meeting any legal obligations).

We will share your information if we are required to by law. We may share your information with enforcement authorities if they ask us to, or with a third party in the context of actual or threatened legal proceedings, provided we can do so without breaching data protection laws.

If you have any concerns about how your personal data is being collected and processed, or wish to exercise any of your rights detailed in our Privacy Notice, please contact: ****Data Protection Officer, Claims Cog Limited, 4th Floor, Telecom House, 125-135 Preston Rd, Brighton and Hove, Brighton BN1 6AF** or call **0333 344 7508**.**