Your Claim Form and Next Steps

We are sorry to hear about the situation that has led you to make a claim. We understand this can be a difficult time, and we want to make the process as simple and straightforward as possible for you. This letter also outlines what will happen next and what you can expect as we guide you through the process.

THE PROCESS:

To start the claim process we kindly ask that you:

Complete all relevant sections of the claim form

Enclosed within the first page of the claim form document you will find a checklist, please read and refer to this checklist as a guide on the sections that you will need to complete.

Provide all requested supporting documents

Provide all requested supporting documents (e.g., ID, payslips, bank statements). The checklist also outlines the supporting documents required and explains why each is needed.

Please contact us and we will be more than happy to help you complete the form or answer any questions you may have.

Return the completed form

Return the completed form along with the checklist, ensuring you have indicated which sections you have completed and which documents you are submitting. Your documents can be submitted to us by email or by post.

Email:
claims@claimscog.co.uk

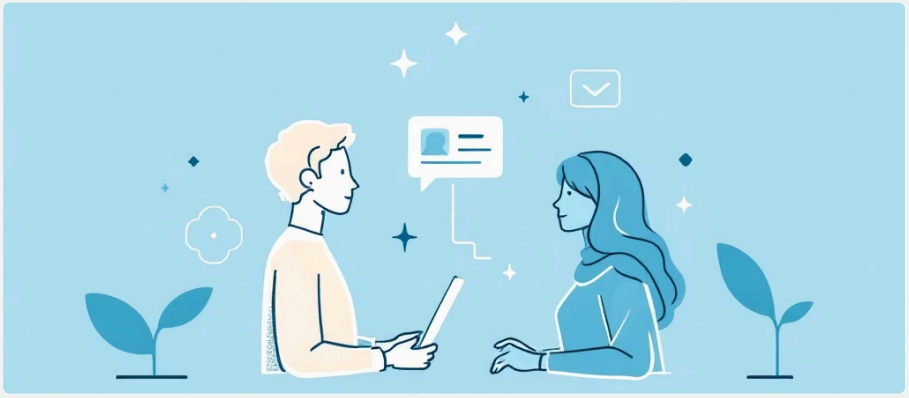
Address:
4th Floor, Telecom House, 125-135 Preston Rd,
Brighton and Hove, BN1 6AF

WHAT HAPPENS NEXT:

Once we receive the completed claim form, we will review the information provided and contact you if anything further is required.

Please be aware that, due to the unique circumstances of each case, we may request additional information beyond what is outlined in the checklist. We may also need to make further enquiries with you or relevant third parties to ensure a fair and accurate assessment of your case.

A dedicated claims handler will stay in touch with you throughout the assessment process, keeping you updated and letting you know if we need any additional information.



Once a decision has been made, you'll receive a final decision letter. This will confirm whether your claim has been accepted — along with a breakdown of your payment schedule — or explain the reasons for any decline, in line with the policy terms and conditions.

About ClaimsCog

ClaimsCog acts on behalf of the insurer for your scheme, providing claims administration services. We manage your claim from start to finish, including the payment of any benefits if your claim is approved. For all claim-related enquiries, please continue to contact us directly.

If you have questions regarding your policy — such as premium payments or policy documents — please contact the policy administrator using the details provided below.

Policy Administrator – Best Insurance

Phone Number: 0330 330 9465

Email Address: customersupport@bestinsurance.co.uk

We are here to provide you with all the help and support you require during this period.

If you have any questions or need assistance in completing the form, please do not hesitate to contact us at **03333 447 508** or **claims@claimscog.co.uk**

Important: Please note that while your claim is being assessed and throughout the duration of your claim period, all premiums on your policy must remain up to date and your cover active. If premiums are not maintained, your policy may be cancelled, and we will be unable to assess any claim under an inactive policy.

Yours sincerely,

The ClaimsCog Team
On behalf of ClaimsCog Ltd.

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ACCIDENT & SICKNESS CLAIM FORM CHECKLIST

All sections highlighted in blue are required to be completed by you. Please go through each section and tick the documents completed and provided. Kindly ensure that all required claim documentation is fully completed and returned, as missing or incomplete sections may result in processing delays.

	Section 1: Personal Details
	Section 2: About Your Employment
	Section 3: Accident Claim *For claims related to an Accident — Please complete this section.*
	Section 4: Sickness / Illness Claim *For claims related to an Illness — Please complete this section.*
	Section 5: GP Section (to be completed by your GP) *Please provide this section of the form to your GP. If your GP returns it to you without a surgery stamp, we will need direct confirmation from them that the form has been completed.*
	Section 6: Employer's Statement (to be completed by your employer) *Please provide this section of the form to your employer. If they return the completed form to you, we'll need them to confirm directly that they have filled it out, as explained in the form.*
	Section 7: For Self-Employed Individuals or Company Directors (to be completed by you or your accountant) *This section should be completed by your accountant. If you do not use an accountant to file your tax returns, you will be required to complete it yourself.*
	Section 8: AMRA *This section must be signed by you. By signing, you give permission for your GP or treating clinician to provide a medical report about your health to support your claim.*
	Section 9: Declaration

ADDITIONAL INFORMATION

As well as the claim form being completed, we require the following additional information to be submitted — the documents highlighted in purple are mandatory.

	Sick Notes *Please provide all fit notes (Med 3) or medical certificates from your GP for the period of your incapacity to work/*

ADDITIONAL INFORMATION

	ID Document — Driving License or Passport *We can accept a photocopy or photo taken of the valid document.*
	12 Months Bank Statements *Please provide your bank statements for the 12 months prior to the submission of your form. The statements must be unredacted and show all account activity for each month. Please note that these statements will be required on an ongoing monthly basis.*
	12 Months Payslips *Please provide your payslips for the past 12 months.*
	Tax Return *Copy of your most recently submitted tax return (if self-employed and/or a company director)*
	Mental Health Claims *Please provide evidence that your condition has been formally diagnosed and that you are under the continuing care of a consultant for the condition that has rendered you unfit for work. Claims cannot be assessed without this confirmation.*
	Neck, Back, or Spine Claims *Please provide radiological medical evidence (such as X-rays, MRIs, or CT scans) showing an abnormality or injury. The evidence must be confirmed by a consultant. Claims cannot be assessed without these documents.*
	Hospital, Treatment, or Appointment Letters *Please provide any documents you currently hold that confirm hospital admissions, treatments received, or appointments attended. This includes appointment letters, referral letters, discharge summaries, test results, or any correspondence detailing the outcome of medical consultations.*
	Additional Supporting Information *Please provide any other information or documents that you believe may support your claim. This could include, but is not limited to, photographs, personal statements, correspondence from healthcare providers, or any other evidence that demonstrates the nature, severity, or impact of your condition on your ability to work. Providing as much relevant information as possible can help us assess your claim accurately and efficiently.*

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Accident & Sickness Claim Form

SECTION 1: PERSONAL DETAILS

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	
Height	
Weight	
Are you a permanent UK Resident?	☐ Yes ☐ No
Name of GP	
GP address & postcode	

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SECTION 1: PERSONAL DETAILS

GP telephone number	
Are you currently taking any prescribed medication? *(If yes, please list the medications and the condition they are treating, as well as how long you have taken this medication)*	☐ Yes ☐ No
Do you have any medical conditions that are separate from what you are claiming for? *(If yes, please provide details, including when you were diagnosed with this condition(s))*	☐ Yes ☐ No

BANK DETAILS

Bank account number	
Branch sort code	
Name of account holder(s)	
Bank name	
Is this a joint account?	☐ Yes ☐ No

Are there any regular payments that you receive into your bank account? *(During our assessment, we will review your statements to understand any incoming transactions. Please help us identify these transactions. Be aware that additional payments may be flagged during our review, and a member of our team will contact you if further clarification is needed.)*	☐ Yes ☐ No *If yes, please provide confirmation of the nature of the payment, for example:* *A Smith — Partner — £200 Standing Order for household bills*

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SECTION 1: PERSONAL DETAILS

Are you claiming with another insurer or on any other insurance policies for this accident or illness? *(If yes, please provide details including policy schedules)*	☐ Yes ☐ No
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
Did you transfer your cover from another provider? *(If yes, please provide a copy of your previous policy schedule)*	☐ Yes ☐ No

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SECTION 2: ABOUT YOUR EMPLOYMENT

Occupation	
Duties	
Were you working full time?	☐ Yes ☐ No
How many hours are you contracted to work each week?	
Was your employment: *(Please select what option applies to you – this will also provide guidance to what sections within this form will apply to you.)*	☐ PAYE ☐ Contract worker ☐ Temporary contract ☐ Agency worker ☐ Seasonal **Please complete Section 3** ☐ Self-employed ☐ Company director **Please complete Section 4**
Employer name	
Employer address	
Postcode	
Employer's telephone number	
Employer's email address	
Basic gross annual income	
Employment start date	
Do you remain employed at this company?	☐ Yes ☐ No
If no: Employment end date	

Are you currently working in any capacity?	☐ Yes ☐ No
If yes, are you working:	☐ Amended duties ☐ Amended hours ☐ Phased Return ☐ Other *If other, please specify:*
Please provide a date that you started working in this capacity	☐ I have been working in this capacity since my accident/illness started ☐ From: _____
Do you have any part time work that you are completing?	☐ Yes ☐ No
If yes, please provide:	**Job title:** _____ **Company:** _____ **Shift pattern:** _____ **Weekly hours:** _____

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SECTION 3: ACCIDENT-RELATED CLAIM

1. NATURE OF INCIDENT

Please describe in detail how the accident occurred	
Date of the accident	
Time of the accident	
Location of the accident	
Were there any witnesses? *(If yes, please provide names & contact information)*	☐ Yes ☐ No

2. INITIAL IMPACT AND SYMPTOMS

What immediate injuries or symptoms did you experience?	
How long after the accident did symptoms appear?	
Did symptoms change or worsen in the hours/days following the accident? *(If yes, please describe)*	☐ Yes ☐ No
Did you receive first aid at the scene? *(If yes, by whom and what treatment was provided?)*	☐ Yes ☐ No

3. MEDICAL ATTENTION

Date of first consultation for this accident	
Was your first consultation with your GP, hospital, or other medical professional?	☐ GP ☐ Hospital ☐ Other *(please specify):* _____
What symptoms or injuries were reported at that consultation?	
Have you had additional consultations or follow-ups?	☐ Yes ☐ No *If yes, please provide the following information:*

Date of consultation(s):	Name and speciality of healthcare professional(s):	Purpose/notes of each consultation:

Have you had referrals to any other healthcare professionals (e.g. physiotherapists, consultants, etc.)	☐ Yes ☐ No *If yes, please attach your appointment letters and provide the following information:*

Referral dates and details:

4. DIAGNOSIS

Have you received a formal diagnosis?	☐ Yes ☐ No *Diagnosis:* _____ *Date of diagnosis:* _____ *Diagnosing medical professional:* _____

If no, what are the next steps to diagnose the condition?	
Is there a suspected diagnosis? *(If yes, please provide details of the alleged condition and what tests will be completed to determine).*	☐ Yes ☐ No

5. TREATMENT

Are you receiving ongoing treatment?	☐ Yes ☐ No *If yes, please list:*

Medications (name, start date, dose)	Therapies (type, start/end dates)	Surgical procedures (type, date, outcome)

Have you been admitted to a hospital?	☐ Yes ☐ No *If yes, please list:*

Date of admission:	Duration of visit:	Reason for visit:	Hospital name:

6. IMPACT ON DAILY LIFE AND WORK

How has the accident affected your ability to perform daily activities?	
How does this accident prevent you from working?	
Are you receiving sick pay from your employer?	☐ Yes ☐ No

7. PREVIOUS OCCURRENCES

Have you previously suffered from injuries related to this accident or similar accidents? *(If yes, please provide full details including dates and treatments received)*	☐ Yes ☐ No

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SECTION 4: SICKNESS-RELATED CLAIM

1. NATURE OF SICKNESS

Describe your illness or condition in detail	
Date symptoms first appeared	
Initial symptoms	
How did symptoms change or progress over time?	
Were there any triggers or events that worsened your condition?	

2. MEDICAL ATTENTION

Date of first consultation for this condition	
Was your first consultation with your GP, hospital, or other medical professional?	☐ GP ☐ Hospital ☐ Other *(please specify):* _____
Symptoms reported at that consultation	

Have you had additional consultations or follow-ups?	☐ Yes ☐ No *If yes, please provide the following information:*

Dates:	Professionals seen:	Purpose/notes:

Have you had referrals to any other healthcare professionals (e.g. physiotherapists, consultants, etc.)	☐ Yes ☐ No *If yes, please attach your appointment letters and provide the following information:*

Referral dates and details:

3. DIAGNOSIS

Have you received a formal diagnosis?	☐ Yes ☐ No *Diagnosis:* _____ *Date of diagnosis:* _____ *Diagnosing medical professional:* _____

If no, what are the next steps to diagnose the condition?	
Is there a suspected diagnosis? *(If yes, please provide details of the suspected diagnosis and what tests will be completed to determine)*	☐ Yes ☐ No

4. TREATMENT

Are you receiving ongoing treatment? *(If yes, please provide details including medications, therapies, and any surgical procedures)*	☐ Yes ☐ No
Have you been admitted to a hospital?	☐ Yes ☐ No *If yes, please list:*

Date of admission:	Duration of visit:	Reason for visit:	Hospital name:

5. IMPACT ON DAILY LIFE AND WORK

How has this illness affected your ability to perform daily activities?	
How does this illness prevent you from working?	
Are you receiving sick pay from your employer?	☐ Yes ☐ No

6. PREVIOUS HISTORY

Have you previously suffered from this condition?	☐ Yes ☐ No *If yes, please list:*

Dates of previous episodes:	Symptoms experienced:	Treatments received:	Impact on daily activities or work:

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SECTION 5: GP SECTION (TO BE COMPLETED BY YOUR GP)

Policyholder's name	
Policyholder's date of birth	
Policy number	
Address	
GP practice name	
GP name	
Practice address	
Contact number	

1. CURRENT MEDICAL CONDITION

Primary diagnosis (if confirmed) OR description of presenting symptoms/ clinical impression (if diagnosis is not yet confirmed)	
Suspected or provisional diagnosis (if applicable)	
Key presenting symptoms	
Duration of symptoms prior to consultation	

Tests or investigations ordered to confirm diagnosis (please include dates if possible)	
Any differential diagnoses under consideration	
Date symptoms first began	
Date patient first consulted you regarding this condition	
Date patient was deemed unfit for work	

Is the patient currently under your care alone for this condition?

☐ Yes ☐ No

If no, please provide the details of any other treating clinician or specialist:

Name:	Specialty:	Hospital:

Cause of incapacity

Please indicate whether any of the following apply to the current condition or incapacity:

- ☐ Intentionally self-inflicted
- ☐ Drugs or alcohol related
- ☐ Due to a medical condition of pregnancy

Cause of incapacity (continued)	*If yes to any of the above, please provide brief details below.*

2. MEDICAL HISTORY

Has this condition (or any related symptoms) been recorded in the patient's medical history prior to the current episode?	☐ Yes ☐ No *If yes, please give details and dates of previous episodes, symptoms, diagnoses, and treatment:*
Are there any other medical conditions (past or present) that may have contributed to or exacerbated the patient's current incapacity?	☐ Yes ☐ No *If yes, please give details for each condition:*

Condition/ diagnosis:	Date of diagnosis/ onset:	Treatment received (if applicable):	Relevance to current incapacity:

Are there any lifestyle factors (e.g. smoking, alcohol, stress, weight, work environment) relevant to this condition?	☐ Yes ☐ No *If yes, please elaborate:*
Has the patient undergone any radiological imaging (X-ray, MRI, CT, ultrasound)?	☐ Yes ☐ No *If yes, please specify the type of imaging, the date performed, and key findings:*

3. TREATMENT AND PROGNOSIS

Treatment prescribed or recommended

☐ Medication ☐ Therapy ☐ Surgery

☐ Other *(please specify):* _____

Name/description:	Dosage/ frequency/ duration:	Start date:	End date:	Clinical rationale/notes:

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Has the patient been referred to or seen by a specialist?	☐ Yes ☐ No *If yes, please provide details for every specialist consulted:*

Specialist name/ practice:	Specialty/ area of expertise:	Date of referral:	Date first seen:	Is the patient under ongoing care?	Key findings/diagnosis:
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Treatments or recommendations from specialist(s):

Is the patient currently following the recommended treatment plan?	☐ Yes ☐ No ☐ Unsure
Current prognosis	☐ Expected full recovery ☐ Expected partial recovery ☐ Chronic or ongoing condition ☐ Unclear at this stage
Estimated date of return to work (if known)	

4. MENTAL HEALTH CLAIMS

Is the patient's current incapacity related to a mental health condition?

☐ Yes ☐ No

If yes, please provide:

Diagnosis (if confirmed):	Date of diagnosis:	Clinical symptoms or presentation:

Is the patient currently under the continuing care of a consultant psychiatrist or other mental health specialist?

☐ Yes ☐ No

If yes, please provide:

Specialist name:	Role:	Contact details (if relevant):

What is the current treatment or management plan for this condition?

Medication:	Therapy/counselling:	Other interventions:	Start & expected end dates:

What is the prognosis/expected impact on work capacity?	

5. CAPACITY FOR WORK

In your professional opinion, is the patient currently completely unfit for work?	☐ Yes ☐ No
If partially fit, please describe any restrictions or suitable adjustments that would enable work	
Has a fit note (Med 3) been issued stating the patient is 'not fit for work'?	☐ Yes ☐ No *If yes, please attach copies.*

6. PRE-EXISTING CONDITION INDICATORS

Does the patient's current condition appear to be a continuation, recurrence, or exacerbation of a previous medical issue?	☐ Yes ☐ No *If yes, please provide details for each relevant previous episode:*

Previous condition/ diagnosis:	Date of onset/ previous episode:	Treatment received at that time:	Relationship to current condition (e.g. continuation, recurrence, exacerbation)

Please indicate any relevant past investigations or diagnostic results	

7. ADDITIONAL COMMENTS

Please use this space to provide any additional clinical information that may assist in assessing the patient's claim, including details on the condition's progression, response to treatment, or expected recovery trajectory	

8. NARRATIVE QUESTIONNAIRE

Please describe the medical condition(s) currently affecting the patient, including diagnosis, onset, and how these impact their ability to work	
Outline the patient's relevant medical history, particularly any similar or related symptoms or conditions	
Is there evidence that the current condition is linked to or exacerbated by a pre-existing condition or previous episode?	

Provide a clear timeline from first presentation to current status, including any treatment, referrals, or investigations undertaken	
Comment on prognosis, likely duration of incapacity, and anticipated recover or return-to-work date	
Add any other observations relevant to assessing the claim or understanding functional limitations	

9. DECLARATION

GP's signature	
Name	
Telephone number	
Email	
Date	
GP address stamp *(If you are unable to provide a GP address stamp, please contact us directly at claims@claimscog.co.uk confirming that you have completed the document)*	

Notes for use:

Please attach any relevant medical reports, fit notes, or specialist correspondence. This information will be used solely for claim assessment and handled in accordance with UK GDPR and the Data Protection Act 2018.

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SECTION 6: EMPLOYER'S STATEMENT (TO BE COMPLETED BY YOUR EMPLOYER)

Employee's name	
Employer/company name	
Employer contact name	
Position	
Contact email	
Phone number	

1. EMPLOYMENT VERIFICATION

Employee's job title/role	
Employee's key duties/ responsibilities	
Date employment commenced	
Employment type	☐ Permanent ☐ Fixed-term/ temporary ☐ Casual/zero hours ☐ Self-employed contractor ☐ Agency worker ☐ Other *(please specify)* _____
Working pattern	☐ Full-time ☐ Part-time ☐ Shift work ☐ Variable or irregular hours
Contracted working hours per week	
Current gross salary/income	£ _____ per ☐ week ☐ month ☐ year
Confirmation of ongoing employment	☐ Yes ☐ No

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2. ABSENCE VERIFICATION

Is the employee currently off work due to illness or accident?	☐ Yes ☐ No
If yes, on what date did they last attend work?	
Have you been receiving regular medical certificates?	☐ Yes ☐ No
Return-to-work status	**Has the employee returned to work at any point during this absence?** ☐ Yes ☐ No *If yes:* Date of first return: ☐ Full-time normal duties ☐ Phased return ☐ Reduced hours ☐ Alternative duties (please describe): **Did the employee subsequently go off sick again?** ☐ Yes ☐ No *If yes, please provide dates and reasons:* **Expected date for full resumption of normal duties (if applicable):**

Has the employee had any previous periods of absence lasting more than 5 consecutive working days at any time during their employment with your organisation? ☐ Yes ☐ No

Start date	End date	Reason	Notes

Has the employee disclosed any ongoing or pre-existing medical condition(s)?

☐ Yes ☐ No ☐ Unsure

If yes, please provide the following details for every condition disclosed:

1. What is the medical condition?

2. Has the condition affected the employee's attendance at work?

☐ Yes ☐ No ☐ Unsure

If yes, please provide specific details, including the dates and duration of any absences:

Has the employee disclosed any ongoing or pre-existing medical condition(s)? (continued)	**3. Have any workplace adjustments or accommodations been made to support the employee?** ☐ Yes ☐ No ☐ Unsure *If yes, please provide details, including type of adjustment, dates implemented, and any ongoing arrangements:* **4. Additional notes or context (optional):**

3. ACCIDENT VERIFICATION (IF APPLICABLE)

Was the absence caused by a workplace accident?	☐ Yes ☐ No *If yes, please provide:*

Date of accident:	**Location of accident:**

Were there any witnesses?	☐ Yes ☐ No *If yes, please provide:*

Names:	**Positions:**

Was the incident reported internally (e.g. accident book or H&S report?	☐ Yes ☐ No

4. RETURN TO WORK PLANS

Has a formal return-to-work plan been discussed or implemented?	☐ Yes ☐ No *If yes, please provide details:*
Are there any restrictions or adjustments planned for the employee upon their return?	☐ Yes ☐ No *If yes, please provide details:*

5. DECLARATION

I declare that the answers I have provided on this certificate are true and complete to the best of my knowledge and honest belief. The answers provided have not been given by my employee, but have come from me, their employer.

Name and address of company	
Postcode	

If the form is returned via the employee, we will still require a confirmation email from you (the employer), confirming the date the form was completed and that it was completed by the employer. Without this confirmation, the form cannot be accepted.

Please either email your completed form directly to us or email claims@claimscog.co.uk confirming that you completed the document.

Company telephone number	

Your name	
Employment title	
Contact number	
Email address	
Signature	
Date of signature	

Note for employers:

This information will be treated confidentially and used solely for assessment of an income protection claim. Please attach any supporting documentation, e.g. HR records, accident reports, absence records, etc.

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SECTION 7: SELF-EMPLOYED (TO BE COMPLETED BY YOUR ACCOUNTANT, OR BY YOU IF YOU DON'T USE THE SERVICES OF AN ACCOUNTANT TO FILE TAX RETURNS)

Claimant name	
Business name (if applicable)	
Business address/contact	
Tax reference number	
Contact phone	
Email address	

1. BUSINESS DETAILS

Nature of business/trade	
Role/responsibilities within the business	
Type of self-employment	☐ Sole trader ☐ Partnership ☐ Limited company director ☐ Contractor/freelancer ☐ Other *(please specify)* _____
Average working hours per week	
Average annual income (gross, before tax)	£
Date self-employment commenced	
Primary income source	☐ Contracts ☐ Clients ☐ Sales ☐ Other *(please specify)* _____

Annual Revenue for the Last Three Years	**Year 1:**	**£**
	Year 2:	**£**
	Year 3:	**£**
Net Profit for the Last Three Years	**Year 1:**	**£**
	Year 2:	**£**
	Year 3:	**£**

Please attach a copy of your most recently submitted Self-Assessment Tax Return.

If your self-employment has been for less than 12 months, please instead provide copies of your invoices and relevant bank statements.

2. WORK INCAPACITY TIMELINE

Please provide a chronological record of incapacity periods & partial work below.

Start date:	End date:	Reason:

Is the claimant currently unable to perform normal business duties?	☐ Yes ☐ No

Expected date of full return to work (if known)	
Has the claimant performed any work in any capacity during this period?	☐ Yes ☐ No *If yes, please describe:*

Date attended:	Hours worked:	Duties carried out:	Modifications made (if applicable):

3. PREVIOUS HEALTH-RELATED WORK INTERRUPTIONS

Has the claimant previously been unable to work for more than 5 consecutive working days due to illness, injury, or other health reasons?	☐ Yes ☐ No *If yes, please describe:*

Start date:	End date:	Reason:

Does the claimant have any recurring health conditions affecting work?	☐ Yes ☐ No *If yes, please provide details:*

4. ACCIDENT/INCIDENT VERIFICATION (IF APPLICABLE)

Was the illness or injury caused by an accident?	☐ Yes ☐ No *If yes, please provide:*

Date of accident:	**Location of accident (if work-related, please specify):**

Were there any witnesses?	☐ Yes ☐ No *If yes, please provide:*

Names:	**Contact details:**

5. BUSINESS CONTINUITY AND ALTERNATIVE WORK

Have any business activities continued in the claimant's absence?	☐ Yes ☐ No *If yes, please provide details:*

Has the claimant undertaken any alternative income-generating work during this period?	☐ Yes ☐ No *If yes, please provide details:*
Accountant's signature	
Print name	
Date	
Telephone number	
Email address	
Company stamp *(If you do not have a company stamp, please contact us directly to validate this information at claims@claimscog.co.uk)*	

Notes for accountant/claimant:

Please attach supporting documentation where available (e.g. tax returns, invoices, contracts, business accounts). All information will be handled in accordance with UK GDPR and used solely for claim assessment.

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SECTION 8: AMRA (TO BE SIGNED BY YOU)

Claims reference	

GP DETAILS

Doctor's name **Surgery address**	
Postcode	
Telephone number	

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 healthcare professional, including GPs, consultants, specialists, therapists, or any other practitioner who has at any time consulted me regarding my physical or mental health. This includes, but is not limited to, medical notes, reports, test results, and consultant reports. I agree that a copy of this consent shall have the same validity as the original and authorise the release of such information.

☐ I do require to see any medical report before it is issued.

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	

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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 apply for a medical report from your doctor, we not only need your consent, but must also 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 within 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 ClaimsCog 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 they have 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 may 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 their costs.

Once you have seen a report before it has been sent to us, the doctor cannot submit it until they have your consent. You can write to the doctor asking them 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 their 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, they 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 ClaimsCog Limited and their agents.

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

SECTION 9: 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 ClaimsCog Limited with any information relevant to this claim if required. I understand a representative of ClaimsCog 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 ClaimsCog 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 of my 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 willfully 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. Failure to provide the required information to complete an assessment in full could delay or mean your claim may not proceed. 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 & Hove, Brighton BN1 6AF

DATA PROTECTION & 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 information about you, and any additional people who 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 & Hove, BN1 6AF** or call **0333 344 7508.****