Paraplegia / Quadriplegia *
Claim Form

(*Delete as appropriate)

To be completed by the Member for whom the benefit is being claimed and returned to:
Northamptonshire Police Federation, The Lodge, Woolton Hall Park, Woolton, Northampton, NN4 0JA
The issue of this form is in no way an admission to liability.

Claimant

Full Name: _____

Date of Birth: _____

Rank: _____ Collar No: _____

Home Address: _____

_____

_____ Postcode: _____

Email Address: _____ Mobile Number: _____

Date of accident: _____/_____/_____ Time: ____:____ hrs Place: _____

Description of accident: _____

_____

_____

Name and addresses of witnesses: _____

_____

Nature of injury: _____

_____

Have you suffered a similar injury before? YES / NO* **(*delete as applicable)**

If yes please give details: _____

_____

Name & Address of the GP in attendance in respect of this injury: _____

_____Tel No: _____

Name & Address of your usual GP:_____

_____Tel No:_____

From what date were you totally disabled from attending your usual occupation? ____/____/____
(If applicable)

Date of medical retirement? ____/____/____
(If applicable)

Is your disability permanent and irreversible and
such that you are unable to perform any gainful employment? YES / NO* **(*delete as applicable)**

Are you unable to exist independently without the continual
supervision and frequent attention of a third party? YES / NO* **(*delete as applicable)**

Is your disablement solely due to the stated injury? YES / NO* **(*delete as applicable)**

If no please give full details: _____

_____

Where you suffering from any physical defects or infirmities prior to injury? YES / NO* **(*delete as applicable)**

Please give below details of any benefit to which may be entitled under any other insurance policy or club scheme with the name and address of the insurers or club:

_____

_____

Please provide any further information you feel is relevant to your claim: _____

_____

_____

_____

_____

Declaration

I agree with the data protection statement below for details of how my information will be used.

I declare that the information given on this form is true and complete to the best of my knowledge.

I confirm that I have been informed of my rights under the Access to Medical Reports Act and consent to the underwriters to whom the claim is submitted (the underwriters) seeking medical information from any medical practitioner who has treated me or who has access to records relating to my physical and mental health, or any other source which is necessary and relevant in the opinion of the Underwriter's Chief Medical Officer.

Please tick one of the following 2 boxes:

I do wish to see any medical reports prior to their release to Aviva. ☐

I do not wish to see any medical reports prior to their release to Aviva. ☐

I also consent to the release of such information to the Underwriter's Chief Medical Officer.

I understand and consent to the use of this information provided on this form, together with medical and other information provided in connection with any claim, for the purposes of underwriting, administration, claim management, rehabilitation and customer concern handling. In order to do this, the information may be shared with other insurers, reinsurers, insurance intermediaries and service providers.

Signed: _____ Date: _____

TO BE COMPLETED BY A TRUSTEE OF THE SCHEME:

I certify that the claimant is a member of the group insurance scheme and that the details are correct. I confirm that the member is covered under the scheme as indicated below:

Date of Joining Scheme: - _____/_____/_____ Date First Eligible to Join: - _____/_____/_____

Signed: _____ Date: _____

Please print name: _____

DATA PROTECTION

Philip Williams Insurance Management, confirm that the underwriter to whom the claim is submitted to is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority (Registration No. 110029) and is registered under the Data Protection Act 1998. In addition to the information gathered from you in relationship to any applications for products, the underwriter also need to maintain other records, mainly in regard to claims made on it.
The underwriter maintains all the information on computer and/or paper files.
Information will only be disclosed to third parties where it is necessary to do so in whatever format is considered appropriate by the underwriter, limited to:

i. Outside consultants and agents, only as may prove necessary in developing, providing or maintaining the services of the underwriter.
ii. Product providers, in relation to products that may be offered by the underwriter operating as an intermediary for specific products.
iii. The Regulators (mainly the Financial Conduct Authority who have legal authority to check all of our records), or governmental agencies with the legal rights to demand disclosure.
iv. The underwriter does not disclose information to third parties other than those stated, not lending, selling or in any other way sharing your personal information.
v. Counselling and support services who you are willing to use and have been approved by the underwriter.
vi. Philip Williams & Co, 35 Walton Road, Stockton Heath, Warrington, WA4 6NW, to whom claim forms should be sent.

ACCESS TO MEDICAL REPORTS ACT 1988

Rights and Procedures

Access to Medical Reports Act 1988, Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

We need your consent before we can approach any doctor for a medical report about you. This is given by signing the declaration on this form. Before you sign, you should read this section carefully. It details your rights under the Act.

1. You do not have to give your consent. If you do not give your consent, we may be unable to proceed with your claim.
2. You can request to see the report before it is sent to us. We will inform the doctor that you want to see the report before it is sent to us and confirm your request in writing. You will then have 21 days to arrange with the doctor to see the report. If you haven't arranged to see the report within this period the doctor will send it to us.
3. If you indicate that you don't want to see the report, we do not have to tell you if we apply for one. You can, however, ask to see a copy of the report within six months of it being sent to us.
4. The doctor may charge you a reasonable fee if you ask to see a copy of the report.
5. If you have seen the report before it is sent to us, the doctor will require your written consent to send it to us. You have the right to ask the doctor to change anything that you consider to be incorrect or misleading. The doctor can, however, refuse to make any alterations. If the doctor refuses to change the report you may attach a note giving your views.
6. The doctor can refuse to let you see all or part of the report if, in their opinion, it is likely to:

- Adversely affect your physical or mental health or that of others,
- Indicate the doctor's intentions to you,
- Reveal the identity of a third party who has given information about you unless they have consented to its disclosure or it has been supplied by a health professional involved in caring for you.

In such cases the doctor must notify you. You will only be able to see the remaining part of the report. If the whole report is affected the doctor will advise you and not send it to us without your written consent. If you refuse to give your consent we may be unable to proceed with your claim.

If your claim is approved the payment will be credited direct to your bank account. Please complete the following details:-

Name/Address of Bank/Building Society:

_____

_____

Name of Account Holder: _____

Sort Code: _____ /_____ / _____

Account Number: _____