

**CLAIMS ARE TO BE SUBMITTED WITHIN 90 DAYS OF A SPECIFIED  
CRITICAL ILLNESS FIRST BEING DIAGNOSED**

**Trustee Statement**

To be completed by the **Trustees** in respect of the person for whom the benefit is being claimed, and returned to **Surrey Police Federation Office, Federation House, Highbury Drive, Leatherhead, Surrey, KT22 7UY** or email to: [admin@surrey.polfed.org](mailto:admin@surrey.polfed.org)  
The issue of this form is in no way an admission of liability.

**Participant's details: -**

Please refer to the Data Protection Statement on page 3 for details on how we will use the Claimant's information.  
**The Trustees of the Surrey Police Group Insurance Scheme in respect of:-**

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Division: \_\_\_\_\_ Rank: \_\_\_\_\_ Collar No: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Email Address: \_\_\_\_\_ Tel No: \_\_\_\_\_

**Serving Officer / Partner of Serving Officer / Child of Serving Officer \*\***

**Police Staff / Partner of Police Staff / Child of Police Staff \*\***

(\*\*delete as applicable)

**Claimant's Details**

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**To be completed by a Trustee of the Scheme: -**

I certify that the claimant is a current participant of the Scheme and that the claim details are correct.

Date of Joining Scheme: \_\_\_\_\_ Date First Eligible: \_\_\_\_\_

Benefit Claimed: £ \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

**To be completed by the person in respect of whom the benefit is being claimed**

**Personal Statement: -**

1. What disease has been diagnosed? \_\_\_\_\_

2. Have you previously suffered from or received treatment for a related illness? **YES / NO \***

If yes, give full details including dates and exact diagnosis (if known):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. On what date did you first note symptoms? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date ceased work (if applicable): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4. Please provide the name and address of your General Practitioner: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Tel No: \_\_\_\_\_

5. When did you first consult your General Practitioner for this condition? \_\_\_\_\_

6. Please provide the name and address of any other doctor / specialist consulted for this condition and/or details of any hospitalisation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Have you ever previously claimed under this policy? **YES / NO \***

If Yes, please state condition: \_\_\_\_\_  
\_\_\_\_\_

**\* Delete as appropriate**

**Declaration**

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

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I do / do not\*** wish to see any medical reports prior to their release to the Society.  
(\*Delete as applicable)

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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:** \_\_\_\_\_

**BANK DETAILS:**

When your payment has been approved we will make the payment to you directly to your bank account.

Name and Address of your bank:	Branch Sort Code: _____
_____	Account Number: _____
_____	**Account Name(s): _____
_____	

**\*\*Please ensure you provide us with the exact account name as it appears on your bank account. Failure to do so will result in a delay in us processing your payment.**

## **DATA PROTECTION NOTICE**

Philip Williams (G Ins) Management Ltd collects and uses your data in accordance with current data protection law (which includes, from 25 May 2018, the General Data Protection Regulation (Regulation (EU) 2016/679)) (“data protection law”). We maintain records in regard to policy claims on computer and/or paper files. Information will only be disclosed to third parties in whatever format is considered appropriate by us. By signing this form, you consent to Philip Williams (G Ins) Management Ltd using your data and the information you have provided to process the claim. Further information can be found in our Privacy Policy at <https://www.philipwilliams.co.uk>

## **Privacy Notice**

**Please Note:** Our Privacy Notice can be viewed on our website at [www.philipwilliams.co.uk](http://www.philipwilliams.co.uk)  
A hard copy can be provided upon request.

## **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.