RISK ASSURANCE MANAGEMENT

CRITICAL ILLNESS CLAIM FORM

Serving Member		Spouse/Partner of Serving Member		Child		Retired Member		Spouse/Partner of Retired Member	

Title: .....

Sex (Male/Female): .....

Full Name: .....

Address: .....

.....

Telephone/Mobile Number: .....

Email: .....

Date of Birth: .....

For all Claims:
Serving/Retired Member's Collar/ Payroll Number: .....

For Spouse/Partner Claims:
Serving/Retired Member's Full Name: .....

For Spouse/Partner Claims:
Serving/Retired Member's Date of Birth: .....

For Retired Member and Spouse/ Partner of Retired Member Claims:
Retired Member's Date of Retirement: .....

Risk Assurance Management Limited,
insurances arranged at Lloyd's

Risk Assurance Management Limited is authorised and regulated by the Financial Conduct Authority

Registered Address:
24 Picton House, Hussar Court, Waterlooville, Hampshire PO7 7SQ
Registered in England and Wales No: 1334065

Chancery House, Leas Road,
Guildford, Surrey GU1 4QW
Tel: 0370 7200 780
Email: group.risk@ram-ltd.co.uk
Web: www.ram-ltd.co.uk

1. **Please describe your condition in full (continue on a separate sheet if required):**

……

……

……

……

……

2. **On what date did you first note symptoms?**

……

3. **On what date was your condition diagnosed?**

……

4. **Please provide full details including dates of any tests/investigations which have been carried out (please provide name, department, reference (if appropriate) and address of the institution where such tests were performed):**

……

……

……

……

……

5. **What treatment are you currently receiving?**

……

……

……

……

6. **Have you previously suffered from the same or any similar condition? Please provide full details including dates:**

……

……

……

7. **Please provide the name and address of your General Practitioner:**

……

……

……

8. **When did you first consult your General Practitioner for this condition?**

……

……

9. **Please provide the name and address of the doctor(s)/specialist(s) consulted for this condition, or details of hospitalisation. Please indicate who would be the most appropriate to contact:**

……

……

……

……

10. **Please provide details of any other insurance policies under which you may receive payment for this condition:**

……

……

……

11. Please provide any further details you feel may help us when assessing your claim:

……

……

……

12. Have you previously made a claim under a Critical Illness Policy? If yes, please provide full details:

……

……

……

I certify that the answers and statements provided above are full and true to the best of my knowledge and belief and that I have not withheld any relevant information from Risk Assurance Management Limited. If you are unsure as to whether any information should be given, you should provide it.

Claimant's signature:

Full Name:

Date:

Access to Medical Reports

It may be necessary for us to obtain medical reports to support your claim. Before we can ask any doctor that you have consulted to complete a report, we need your permission under the Access to Medical Reports Act 1988. Your rights under the Act are as follows:

a) You do not have to give your consent, but if you do not we may be unable to proceed.

b) You can ask to see the report before the doctor returns it to us. If you do, we shall tell the doctor to retain the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.

c) If you choose not to see the report at this stage, you may ask the doctor for a copy within 6 months of it being sent to us. A duplicate report can be sent to your doctor on request should you wish to see it at a later date.

d) If you consider any aspect of the report to be incorrect or misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask them to attach a statement outlining your views, which will then accompany the report.

e) Your doctor can withhold access to the report if they feel that it would cause physical or mental harm to you or others.

f) Your medical report will contain details of relevant consultations, treatment, operations, investigations and test results that you have undergone at any surgery, hospital or clinic. Your consent will give Risk Assurance Management Limited access to this information.

If you have any questions regarding your rights under the Act or any questions relating to the process of obtaining, assessing or storing medical information, please write to the Compliance Officer at our Head Office.

Please tick one box

I wish to see reports before they are sent to the Company. ☐

I do not wish to see reports before they are sent to the Company. ☐

Settlement of this claim will be made by electronic transfer to the Member:-

Please ensure that the bank account details provided below are full and accurate – failure to do so may delay settlement of the claim.

Member's Bank Details:	
Bank Account Name:	.....
Bank Account Number:	.....
Bank Sort Code:	.....
Bank Name:	.....
Bank Address:	.....
	.....

Data Protection

I understand that the use of any information provided by me for the operation of this insurance is for the process of underwriting, administration, claims management, handling customer concerns and the detection, prevention and investigation of fraud.

I understand that in order to do this the information may be shared with other insurers, reinsurers, insurance intermediaries and service providers who are involved in either the operation of insurance which covers members or the member's benefits arrangements provided by the Company in accordance with the Data Privacy Notice shown on our website: www.ram-ltd.co.uk.

I understand the data will be processed fairly and securely and the details will be stored on computer but will not be kept longer than necessary.

I understand that the data I have provided in relation to this insurance will be processed in accordance with the requirements of the General Data Protection Regulation.

Declaration

I hereby certify that the information provided is truthful, accurate and complete and I agree that any statement made by me and found by Risk Assurance Management Limited to be false or inaccurate could affect how much is paid out on the claim and could mean the claim is not paid out at all.

I authorise any doctor, other medical practitioner, or any other person to provide Risk Assurance Management Limited, their agents or subcontractors with all information as requested by the company or its representative in consideration of the claim.

Copies of this declaration will be legally valid.

I confirm I have read and understood the information in this claim form including the section relating to:

- Access to Medical Reports Act 1988
- Data Protection
- The Declaration

I understand that Risk Assurance Management Ltd may ask other insurers for information to check the information I have given.

Claimant's signature:
Full Name:
Full Address (including postcode):
Date:

Trustees Declaration

We hereby apply to Risk Assurance Management Limited for payment of the Critical Illness Benefit claimed. We declare that the claimant is a Member of the Scheme and paying premiums up to the date of diagnosis and the particulars provided are correct to our knowledge and belief. We confirm that payment of this claim will discharge all liability in respect of this Member for the Insured Illness upon which the claim was settled and such related Insured Illnesses as stated in the Policy.

TO BE COMPLETED BY THE TRUSTEES

Critical Illness benefit amount being claimed (£): ……..

Date Claimant joined the Scheme: ……

For all claims - Date Serving/Retired Member joined the Force: ……..

For Serving Member claims - Date last day Actively at Work: ……..

For Retired Member and Spouse/Partner of Retired Member claims - Date of Retired Member's Retirement: ……..

This form must be signed by a Trustee of the Scheme or a duly authorised person on behalf of the Trustees.

As part of our claims process, we must be able to verify the signature against specimen signatures we hold on file.

Authorised Signature: ……

Print Name: ……..

Position: ……..

Date: ……..