



Claim Form

Income protection from the *original* provider

Date Produced:

Failure to disclose relevant information may result in non payment of claim

Please read the guidance notes which accompany this form. Answer all the questions on this form in full and forward it to the Society as soon as possible, but within 14 days, together with a Medical Certificate, if not already supplied. Please note a Medical Certificate dated from the start of your incapacity must be supplied by any member whose sick pay entitlement exceeds £30.00 per week Claims for benefit of £30 per week and less must supply a certificate if the claim exceeds seven days. Medical Certificates must be supplied throughout all claims. Failure to provide full information by the due date and/or the Medical Certificate may delay consideration of the claim and result in loss of benefit.

N.B. Sickness Benefit is paid twice monthly, on 15th day and on the last working day of each month (See Section 4 for more information).

Section 1 : Personal Details

Title _____ Surname _____

First Name(s) _____

Address _____

Address _____ Town/City _____

County _____ Postcode _____

Daytime Tel.No _____ Evening Tel.No _____ Mobile No _____

Email _____

National Insurance Number _____

Date of birth dd mm yyyy Age

Marital Status _____

Policy Number:

Section 1b : Occupation Details

Employed

Please provide details of your employer.

Title _____ Surname _____

First Name _____

Address _____

Address _____ Town/City _____

County _____ Postcode _____

Daytime Tel.No _____

Email _____

How Long Have you worked for this Employer? Years Months

What was your occupation prior to incapacity?

Please describe your normal duties:

Please provide a copy of your job description and/or contract of employment if applicable

Section 1b : continued

Self Employed

What is your occupation?

What was your occupation prior to incapacity?

How long have you been Self-Employed? Years Months

Please describe your normal duties:

All Claimants

How long do you spend doing each of the duties of your job?

Whilst working, do any environmental conditions aggravate your condition? Yes No
(e.g. exposure to dust causing respiratory symptoms) If so, please give details of them and their affect.

Please give details of any manual or physical work and percentage of time spent on these duties.

Are there any special skills or tools required to carry out your occupation? Yes No
If so, please give details of them.

What are your contracted hours or the number of hours you would normally work in a week? Hours

Please provide the name and address of your tax office.

Name	Address		
Address	Town/City		Postcode
County	Postcode		

If you are retired or not employed, please state your previous occupation, the date and reason why your previous employment ceased.

What condition are you (or have you been) suffering from?

Section 2 : Claim Details

Please describe your current symptoms.

Is your incapacity caused by an accident? Yes No

If yes, please give details of how the accident happened.

Are you or do you intend to seek compensation or start legal proceedings from any third party as a result of your injury or illness?
 Yes No

If yes, who are you intending to claim from? Please provide the name and address of the solicitors acting for you.

NB. If you are claiming compensation, you should include in your claim any loss of income. On a satisfactory conclusion to your claim any sickness benefit paid to you will have to be repaid to the Society.

Please give the date on which you started to suffer symptoms and describe the symptoms at this time.

On what date were you unable to carry out the duties of your occupation?

Did you work on that day? Yes No

Have you done any work (paid or unpaid) since that day? Yes No

If yes, please give details.

When did you first seek medical advice and from whom?

What is the name and address of your Doctor?

Name

Address

Address

Town/City

Postcode

Daytime Tel. No

A medical certificate dated from the start of your incapacity must be supplied for claims exceeding £30.00 per week

Have you enclosed copies of all medical certificates issued by your doctor related to this incapacity? Yes No

Failure to disclose relevant information may result in non payment of claim

Section 2 : Claim Details Con't

Have you consulted any other Doctor, Consultant or Specialist or been referred to hospital in relation to your incapacity?

Yes No If yes, please give details below:

Name & Address	Date of first Appointment	Date of next Appointment	Date of final Appointment (if known)
Doctor:			
Consultant:			
Specialist:A1			
Name(s) of Hospital Doctor:			

Have you ever suffered from the same or similar condition before? Yes No If yes, please give details below:

What treatments are you receiving, e.g. medication, physiotherapy? Please give name and dosage of any medication.

Have your symptoms improved since starting treatment? Yes No If yes, please give details below:

What duties of your occupation are you unable to carry out and why?

Are there any duties that you do feel you could carry out? Yes No If yes, please give details below:

If you are employed, have you discussed a return to work with your employer? Yes No If yes, please give details below including name and contact number:

When do you expect to recover from your incapacity?

Are you insured against sickness and/or accident with any other company? Yes No

If yes, please give details below:

Name & Address of Insurer	Policy Number	Type of Benefit	Deferred Period	Benefit Level	Status of your claim

Section 3: Financial Details

Employed

Please give your gross income as declared for tax purposes for the period of 12 months prior to your incapacity. £

Please enclose one payslip showing your normal salary and a payslip showing loss of income.

Sub-contractors please supply P60 and a copy of last Tax Return.

Will you receive any continuing income from your employer during your incapacity? Yes No

If yes, please give details below:

Will you receive any other income during your incapacity e.g. pension, rental income etc? Yes No

If yes, please give details below:

Self Employed/Director of a Limited Company

If you are a Self Employed Sole Trader/Self Employed Partnership/Director of a Limited Company, please complete the enclosed questionnaire.

If you have any queries regarding the supply of the income details we require, please contact the Claims Department on 01452 782754.

Section 4 : Claim Payment Details

Our preferred method of payment is by direct credit into your Bank or Building Society Account. Please complete the details requested in order for your claim to be made direct to your account.

Name of Bank:													
Account Name				Bank Sort Code				Account Number					
OR													
Name of Building Society:													
Society Reference (Your Account Number)				Sort Code				Building Society Account Number					

Payments by Direct Credit are made around the 15th and last working day of each month and will reach your account 3 working days after the payment date.

Data Protection

The information provided in the claim form will be used to carry out an initial assessment of the claim and to collect any medical reports or information required by Holloway Friendly to establish the basis of your claim. Information collected will be used to set up and administer the claim. A copy of the claim form and any supporting information, including medical reports, may be given to a reassurance company if the risk is shared with the reassurance company. Any information which is provided in connection with your claim will be used only for underwriting and claims purposes.

If you would like to request a copy of the information held about you, please write to the Holloway Friendly Data Protection Co-ordinator. A fee may be charged for providing information. The information you have supplied will be kept confidential and will not be disclosed to any other party without your consent, unless it is lawful to do so.

Some services are provided to Holloway Friendly by third parties such as underwriting and claims control or obtaining compliance or regulatory advice which warrant the disclosure of more than just your basic contract details. You agree that personal information held by Holloway Friendly may be disclosed on a confidential basis, and in accordance with Data Protection Act 1998, to any such third parties. You also agree that this information may be transferred electronically, e.g. email and you agree that ourselves, or any such third party may contact you in the future by any means of communication which we consider appropriate at the time.

ACCESS TO MEDICAL REPORTS ACT

Before we can assess your claim we may have to obtain a medical report from a doctor who has cared for you. The Access to Medical Reports Act 1988 or Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 gives you certain legal rights over these reports. Briefly your rights are as follows:

1. Before we can apply for a medical report from a doctor who has cared for you, we need your agreement. You can refuse but in this case we will not be able to admit your claim and pay you benefit.
2. You can ask to see a report before your doctor sends it to our Chief Medical Officer or you can ask your doctor to see a copy of the report for up to six months after it has been sent to us.
3. If you think part of the report is incorrect or misleading when you see it, you can ask to have it changed. If your doctor will not agree to this, you may attach a statement of your own.
4. Your doctor does not have to let you see the report if he or she believes it is not in the interests of your health, or if the interests of other people have to be considered. Once you have seen the report your doctor cannot return it to us unless you agree.
5. If we need a report and you have said you want to see it before it is returned to us, we will write to let you know. You will then have 21 days to contact the doctor to arrange to see the report. After this period the doctor will be free to return the report.

I do not wish to see this report before it is sent to Holloway Friendly.

If you wish to see the report please tick this box

General Declaration and Consent

I declare that to the best of my knowledge and belief the information on this form is true and complete and I undertake to provide any additional information which may be required for the assessment of my claim.

I consent to Holloway Friendly seeking information in connection with my claim from any medical practitioner, hospital, specialist or any other person or 3rd party source the company deems necessary. I understand that this may include but may not be limited to Department of Works and Pensions, H. M. Revenues and Customs, Reinsurers. I also authorise the giving of such information to any party Holloway Friendly deem appropriate in the assessment of my claim.

Third Party Access

Should you wish to consent for a third party to be able to discuss your claim with us (e.g. Partner, Family member) please provide their details below:

Name:	Date of Birth:
Connection to you:	

PLEASE SIGN AND DATE THIS FORM HERE

Signature	Date
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Fraudulent Claims

A fraudulent claim will result in the avoidance of the policy, premiums being retained by Holloway Friendly and with any funds standing to the claimant's credit being forfeited to the Society's General Fund and used for the benefit of other members. Appropriate action will be taken to inform any relevant authorities to proceed with further action.

Checklist

- | | |
|---|--------------------------|
| Claim form has been fully completed | <input type="checkbox"/> |
| Job description/contract of employment enclosed | <input type="checkbox"/> |
| P60/CIS form plus payslips | <input type="checkbox"/> |
| Financial Questionnaire | <input type="checkbox"/> |
| Accounts/tax return/SA302 | <input type="checkbox"/> |
| Sick certificate/s | <input type="checkbox"/> |
| Bank account details completed and correct | <input type="checkbox"/> |
| Declaration and consent signed and dated | <input type="checkbox"/> |

Once you have completed this form please return to:

Claims Dept Fax: 01452 386859
Holloway Friendly Tel: 01452 782754
Holloway House
71-73 Eastgate Street
Gloucester
GL1 1PW
Email: claims@holloway.co.uk



Holloway House
71 Eastgate Street
Gloucester
GL1 1PW

tel: 01452 526238
fax: 01452 386859
email: mail@holloway.co.uk
web: www.holloway.co.uk