

Critical Illness Cover Claim Form

How to complete this Claim Form

As soon as practical after the date of diagnosis of an insured critical illness or surgery please fully complete this form in CAPITAL LETTERS.

Please note that in order to satisfy a claim, the insured person's illness must meet the definition of the relevant critical illness described in the Policy Terms and Conditions.

Our initial requirements in order to start processing this claim are:

1. A fully completed personal statement signed by the insured person
2. Original Birth Certificate and Marriage Certificate or legal change of name documentation.
3. Completion of the Declaration and Consent form as we may need to obtain full medical records from the insured person's GP in order to validate the claim.

These should be sent to:-

**Compass Underwriting Ltd, Claims Department, 30 Dukes Place, London EC3A 7LP.
Freephone number: 0800 032 7775 Fax: 020 7398 0109 Email: claims@compassuw.co.uk**

Please be advised that all calls are recorded for accuracy, training and monitoring.
(We recommend that you send your claim documents by recorded delivery)

The completed claim form and personal statement must be sent to us no more than 6 months after the date of the insured illness.

Once we have received all our initial requirements we will advise you within 10 working days;

- i. Of any further information we require to assess your claim
- ii. If we are unable to process the claim and why

We will then obtain details of your medical history and treatment from your General Practitioner and/or consultant.

Details about the Person Insured

1. Certificate Number or Policy Number

2. Full Name

3. Your date of birth

D	D	M	M	Y	Y
---	---	---	---	---	---

4. Your full address

Postcode

5. Your telephone number

6. Your e-mail address

7. Nature of the illness

8. Has any previous critical illness claim been submitted?

 Yes No

If Yes, please give full details

Critical Illness Claim Form

Personal Statement

Please complete in CAPITAL LETTERS where possible.

The issue of this form is not an admission of liability.

This form must be completed by the person in respect of whom the benefit is being claimed.

1. Please describe fully the nature and extent of your illness

2. On what date did you first consult a medical practitioner in connection with your illness?

D		D		M		M		Y		Y
---	--	---	--	---	--	---	--	---	--	---

3. Was this your usual medical practitioner?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

4. What symptoms preceded diagnosis of the illness and when did they start?

SYMPTOM	DATE

5. Have you undergone any tests or investigations to confirm the diagnosis?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

If yes, please provide dates and details

TEST OR INVESTIGATION	DATE

6. What was the date of diagnosis?

D		D		M		M		Y		Y
---	--	---	--	---	--	---	--	---	--	---

7. Please advise whether a surgical operation will be, or has been, carried out

8. Date of surgery, (if applicable)

D		D		M		M		Y		Y
---	--	---	--	---	--	---	--	---	--	---

Medical Consultants

1. Please give the name, address and telephone number of your usual General Practitioner

	Postcode
Telephone number	

2. Have you consulted any other doctor or specialist, or attended a hospital either as an in-patient or out-patient?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

If yes, please give full details including names, addresses, telephone numbers and your hospital reference number if known.

Consultant 1	Consultant 2
Name and speciality	Name and speciality
Address	Address
Telephone number	Telephone number
Hospital reference number	Hospital reference number
Date of consultation or admission	Date of consultation or admission
Date of discharge	Date of discharge

Data Protection Notice

Any personal information you provide will be treated in accordance with the data Protection Act 1998.

By signing this form you consent to Compass Underwriting Limited using and sharing your personal information as set out in this notice. If you are submitting personal information about another person by signing this form you confirm that you have their consent to provide such information to Compass Underwriting Limited and for their information to be used as set out in this notice.

Using personal information

Compass Underwriting Limited uses personal information to undertake any activity relating to its policies, products and services and, where relevant, to process applications, set up and administer policies, products and services and handle any claims.

Sharing personal information

Compass Underwriting Limited may share personal information

- with any of its insurers, service providers, reinsurers and regulators
- with other insurers
- with other companies, organisations and associations and/or credit reference agencies in order to prevent financial crime or fraud
- in any circumstances if permitted or required to do so by law or if Syndicate 779 has consent to do so

Accessing personal information

A person whose personal information is held by Compass Underwriting Limited has various rights including the right to:

- have any incorrect personal information corrected and/or
- access the personal information held for which a fee may be charged

To do so and/or if you need more information please contact Compass Underwriting Limited

Important Notes

- In order that we can assess this claim this may involve us, or another company authorised by us, asking your doctor to provide us with a report, or contacting you to make arrangements for a medical examination, should we require this. We will need to share the information in this form with that authorised company for that purpose
- We may ask you to contact your doctor to speed up the completion of reports that we have requested
- You should give the answers in this form personally. If the answers are filled in by anyone else then they must be read over and agreed by you before the declaration is signed. Any amendments or alterations should be initiated by you
- The questions asked in this form cover the facts that we regard as being material to our assessment of this claim. If you are in any doubt about the information required you should disclose full details. If you do not disclose all relevant facts the claim may be rejected or reduced
- We have a confidentiality agreement in place which means we hold your medical information securely and access is limited to authorised individuals who need to see it.

Accessing Your Medical Reports – Your Rights

We may need to get medical reports in order to assess this claim. Before we can ask any doctor that you have consulted to fill in a report we need your permission under the Access to Medical Reports Act 1988. Your rights under the Act are as follows;

1. You do not need to give your permission but if you do not we may not be able to assess this claim
2. You can ask to see the report before the doctor sends it to us. If this is the case we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within that time your doctor will send the report to us
3. 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. We can send a copy of the report to your doctor if you ask to see it at a later date
4. If you think that any part of the report is incorrect or misleading you may ask the doctor to amend it. If your doctor refuses to make the amendments you may ask for a statement outlining your views to accompany the report to us
5. Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

The medical report your doctor fills in asks about the following:

Your current health

- i. any care, medication or treatment you are currently receiving
- ii. the results of referrals or tests you are waiting for
- iii. any time off work in the last 3 years

Your past health

- i. Details of any relevant illness, trauma or referrals for specialist advice or treatment, hospital admissions, consultation with your GP or any other medical adviser, therapist or counsellor.

If you have any questions about your rights under the Act or questions relating to the process of getting, assessing or storing medical information please write to Compass Underwriting Limited.

Your Declaration and Consent

To the best of my knowledge and belief the information I have given on this claim form is complete and true and contains all material facts. A material fact is one that will influence how this claim is assessed. Failure to give complete and true answers and disclose all material facts could result in the payment of any benefit being refused. If there is any doubt as to whether a certain fact is material it should be disclosed.

I agree to you asking any doctor I have consulted about my physical or mental health to provide medical information so you may carry out your assessment of my claim. You may gather relevant information from other insurers about any other applications for life or critical illness insurance that I have applied for. I authorise those asked to provide medical information on production of a copy of this consent form.

I **do/do not*** want to see the report before it is sent to the company (*delete as appropriate)

I authorise you to pass results from any independent medical examination held or associated test to my own doctor

I agree that a copy of this declaration will have the validity of the original

I authorise you to share any medical information with another insurer should information be requested

I allow you to carry out your assessment of this claim using the information I have given.

Signed

Name

Dated