Esmi Essential Supplementary Medical Insurance

Sick Pay
Continuation Claim Form

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CONTINUATION CLAIM FORM

IMPORTANT INFORMATION:

1. You must fill in the correct sections of the claim form including the Declaration (section B). If you do not return this form in time it may affect your rights to continue to receive benefit under this insurance.
2. Please make sure that you answer all the questions fully and return the form to us with a copy of your medical fit note for the current period being claimed on or around the date requested by our claims dept. Failure to fully complete the form will result in the form being sent back to you which will delay the processing of your claim. You can use the space provided on the reverse of this form if you need to provide any further information.
3. One of our appointed representatives may visit you while you are claiming. Failure to see them could invalidate or seriously delay your claim. Return this and the fit note(s) to: Compass Underwriting, Claims Dpt Suite 214, 75 King William Street, London, EC4N 7BE,. Tel: 0203 758 9744, email: info@compassuw.co.uk or facsimile 020 7398 010. Compass Underwriting are a trading name of Vivet Ltd.

SECTION A (to be completed by the Claimant)

1. Certificate No:

2. Date of Birth

3. Telephone No

4. Full Name

5. Address

Postcode

6. Have you undertaken **ANY** employment of any kind during the past month? (regardless of whether paid or not) Yes ☐ No ☐

(if **YES** please give full details and dates in the section provided overleaf)

7. Have you undertaken **ANY** courses, rehabilitation or training during the past month? Yes ☐ No ☐

(if **YES** please give full details and dates in the section provided overleaf)

8. Do you remain unable to work? Yes ☐ No ☐

If **NO** when did you return to work?

If **YES** please state the reason that you remain unable to work

What are your symptoms and how often do you experience them on a daily basis?

9. Has your GP referred you to a specialist or consultant? Yes ☐ No ☐

If **YES** please give full details including date of next appointment)

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10. Do you have problems with any of the following activities?

a) Walking	Yes		No		b) Sitting	Yes		No		c) Standing	Yes		No	
d) Driving	Yes		No		e) Lifting	Yes		No		f) Climbing Stairs	Yes		No	
g) Bending	Yes		No		h) Exercising	Yes		No		i) Dressing	Yes		No	
j) Personal Hygiene	Yes		No		k) Shopping	Yes		No						

PLEASE ENCLOSE YOUR LATEST MEDICAL FIT NOTE SIGNED BY YOUR USUAL DOCTOR OR SURGERY

FURTHER INFORMATION

Please provide further information for any questions overleaf stating the question number

Question No.	Details

SECTION B Declaration (to be completed by the Claimant)

I hereby declare that the above statements are true in every respect to the best of my knowledge and belief and that I have disclosed all additional information likely to influence the continued payment of my claim. I consent to the seeking of information from my past and present employers, the Benefits Agency and any doctor or medical practitioner who has treated me or any person/organisation that the insurers deem necessary, and I authorise the giving of such information.

A copy of this authorisation shall be considered as effective and valid as the original.

I understand and agree that information regarding my claim may be shared with other insurers, insurer's loss adjustors and the Benefits Agency for fraud prevention purposes and that I consent to my claim being investigated as part of this process.

DATA PROTECTION ACT 1998 I hereby consent to any information you have about me being processed by you for the purposes of providing insurance and claims handling, which may necessitate your providing such information to third parties.

Signed

Date