

# Income Protection Claim Form

## PROCEDURE FOR FILING A CLAIM

- 1) In order to make the process of claiming as simple and straight forward as possible, Please complete this form as comprehensively as you can. This way, we can process your claim most efficiently, enabling us to speed up the process of re-imburement. The form should be used for only one individual.
- 2) **Answer all questions on both sides of the form.**
- 3) Please ensure that this claim form is sent to us no later than 3 months after the date of service to which this claim relates (i.e. if your illness occurs on the 15th March, your claim must be received by us before the 15th June).
- 4) Are you, the policyholder, covered under any other group plan, H.M.O., Social Security or Government Plan, or individual insurance policy, which will pay any of these expenses of this claim?  
 NO  YES, please identify plan and describe benefits: \_\_\_\_\_

## A. Claimant

- 1) Family Name: \_\_\_\_\_ 2) First Name: \_\_\_\_\_
- 3) Group: \_\_\_\_\_ 4) Policy ID/Number: \_\_\_\_\_
- 5) Tel No: \_\_\_\_\_ 6) E-mail Address: \_\_\_\_\_
- 7) Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Postcode: \_\_\_\_\_
- 8) Occupation: \_\_\_\_\_

## PAYMENT DETAILS

- Payment direct to policyholder  Payment in invoice currency  Other currency (please specify) \_\_\_\_\_
- Account Beneficiary Name: \_\_\_\_\_ Sort / Branch code: \_\_\_\_\_
- Name of bank: \_\_\_\_\_ Account No. / IBAN: \_\_\_\_\_
- Address of bank: \_\_\_\_\_ SWIFT code: \_\_\_\_\_

## B. Income Protection Claim

- 1) What is the nature of your injury/illness? If an injury, describe how it occurred: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 2) On what date did the injury or symptoms of your illness first appear? If an injury, provide date of accident?  
\_\_\_\_\_
- 3) Have you ever suffered from this injury or illness before?  No  Yes, when and for how long? \_\_\_\_\_
- 4) What date did you last attend your place of work? \_\_\_\_\_
- 5) From what date have you been totally unable to work? \_\_\_\_\_
- 6) When you were unable to work were you in receipt of any salary (including any half pay), other insurance benefits or pension?  
 No  Yes, what amount you have received to date? \_\_\_\_\_
- 7) How much is the benefit amount per month? \_\_\_\_\_
- 8) With regard to any salary, other income, insurances or pensions are you still awaiting a decision on what you may receive?  No  Yes  
If Yes, what is the benefit amount you expect to receive per month? \_\_\_\_\_
- 9) Have you returned to work?  No  Yes, please state the date you returned to work on? \_\_\_\_\_

If you answered YES for Questions 6 and 8, please complete section C.

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

### C. Other Insurance(s)

Do you have any other income protection, accident/illness, loan protection, credit card protection, mortgage protection or PHI, pension or similar?  No  Yes, please state the following for each insurer who has provided you cover.

- 1) Name of Insurer/Pension Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Postcode: \_\_\_\_\_  
Telephone Number for the claims or pension administration department: \_\_\_\_\_  
Policy/Claim/Pension reference number (not HealthCare International): \_\_\_\_\_
- 2) Name of Insurer/Pension Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Postcode: \_\_\_\_\_  
Telephone Number for the claims or pension administration department: \_\_\_\_\_  
Policy/Claim/Pension reference number (not HealthCare International): \_\_\_\_\_

**If you have more insurers/pension providers, please provide their details on a separate sheet.**

### D. Employer

Please complete the following questions so that your employer can identify you and provide us the information, as set out under the Data Protection Act 1998, as we need your consent so that we can complete our assessment of your income protection claim.

- 1) Your Employee/Payroll Number (as shown on your pay advice slip): \_\_\_\_\_  
2) The name of your employer: \_\_\_\_\_  
3) Employer contact address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Postcode: \_\_\_\_\_  
4) Your National Insurance Number or Social Security Number: \_\_\_\_\_

### E. Doctor

- 1) Name of doctor: \_\_\_\_\_ 2) Name of hospital/clinic: \_\_\_\_\_  
3) Qualifications/credentials: \_\_\_\_\_ 4) E-mail: \_\_\_\_\_  
5) Telephone: \_\_\_\_\_ 6) Fax: \_\_\_\_\_  
7) Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Postcode: \_\_\_\_\_

### F. Authorisation

I hereby certify that the information provided is correct and true to the best of my knowledge. I also confirm that if this claim relates to a pre-existing condition that has not been accepted by the insurer in writing, it may not be approved for payment. I understand that in the event that this claim being misleading or fraudulent, in whole or part, the policy will be invalidated.

**I authorise any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, insurance company, my employer or other person or firm to provide HealthCare International or their authorised representative information, including copies of records, concerning advice, care, or treatment provided to me and/or my dependents, including without limitation, information relating to all medical and mental illness or use of drugs or alcohol.**

In order to process this claim for benefits, I authorise the release to HealthCare International or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photo copy of this authorisation shall be considered as effective and valid for the duration of this claim. I understand that I have the right to receive a copy of this authorisation.

Signed by insured: \_\_\_\_\_

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