Farmsure Underwriters Limited

PERSONAL ACCIDENT CLAIM FORM

Please complete this form as fully as possible. If there is insufficient space please use a separate sheet of paper.
If the claim is for Agricultural Wages Compensation it will be necessary to also complete a supplementary form.

ABOUT THE POLICYHOLDER

Name of Policyholder		Policy No.	
Address		Tel. No.	
		Email	
Occupation			

ABOUT THE INJURED PERSON

What is the name of the injured person?	
What is the address of the injured person?	

Date of birth		Relationship to the Policyholder	

What is the occupation of the injured person?	

ABOUT THE ACCIDENT

Where did it occur?	

On what date?		At what time?	

Describe what happened and the nature of the injury	
Give name and address of any witness to the incident	

DETAILS OF DISABLEMENT FROM USUAL OCCUPATION

When did the disablement start?

If it has ended, when did it end?

Has the injured person previously suffered from the same injury?

If yes, provide details

Was an insurance claim made?

MEDICAL TREATMENT

Did the injured person receive medical treatment?
If yes, provide details

Is medical treatment ongoing?

Name of Doctor now attending the injured person

Address of Doctor
Note – the Medical Certificate overleaf is to be completed by this Doctor

Name and address of usual Doctor if different from above

DECLARATION

I/We declare that the information given on this form is true to the best of my/our knowledge and belief. I/We understand that information may be requested from other parties to check the information that has been given.

Signature of Policyholder

Date

Print name

Position

The Medical Certificate on the following page is to be completed by the attending Doctor

The Consent Form on the final page is completed by the Injured Person

MEDICAL CERTIFICATE

To be completed by the attending Doctor for the purposes of an insurance claim

This is to certify that

is suffering from

and will/will probably (delete as necessary) be unfit to resume work until

Disablement from engaging in or attending to usual occupation was from

Total Disablement	from	/ /	Partial Disablement	from	/ /
	to	/ /		to	/ /

Total Disablement occurs when the person is **wholly** prevented from attending to usual working activities.
Partial Disablement applies when the person is able to carry out some elements of usual working activities.

Has the person ever suffered from the same or similar complaint or condition in the past?

If yes, please provide details

Signature

Date

Name

Qualifications

Address

ACCESS TO MEDICAL REPORTS ACT 1988

We may require completion of a medical report by the doctor who is caring for you, to enable us to deal with an insurance claim. We need your consent to the supply of this report by signing in the space indicated below. Before doing so, however, you should read this note carefully, as it sets out your rights under the Access to Medical Reports Act 1988 and the procedures for dealing with reports. You do not have to give your consent to our being provided with a report but if you do, you have the right to tell the doctor you wish to see the report before it is sent to us, in which case the doctor cannot send it to us unless either he has shown it to you, or 21 days have passed without you having contacted your doctor about arrangement for you to see it. Of course, the quicker you act, the quicker the claim can be considered, and we may not be able to proceed with the claim in the absence of medical information.

Whether or not you say you wish to see the report before it is sent to us, the doctor must let you see a copy for up to six months after it is supplied, if you ask.

If you ask the doctor for a copy of the report, he can charge you a reasonable fee to cover his costs.

Once you have seen a report, before it is sent to us the doctor cannot submit it until he has your consent. You can write to the doctor asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your views on any part where you and the doctor are not in agreement and which the doctor is not prepared to alter.

The doctor is not obliged to let you see any part of a report if, in his opinion, it would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the doctor's intention towards you, or if disclosure would be likely to reveal information about, or the identity of another person who has supplied information about you unless that persons has consented or the information relates to, or has been supplied by a health professional involved in caring for you. In such cases, the doctor must notify you and you will be limited to seeing any remaining part of the report. If it is the whole report which is affected, he must not send it to us unless you give your consent.

Summary

Before your Insurer, or any agent acting on its behalf, can apply for a medical report from your doctor, you need to give your consent. Before signing in the space below, you should know that you have certain rights under the Access to Medical Reports Act 1988 as detailed above, but the main points are as follows;

- You can withhold your consent
- You can see the report before it is sent to us, or during the six months after that
- You can ask the doctor if he will amend any part of the report which you consider to be incorrect or misleading. If the doctor is not in agreement, you may append your comments
- The doctor can withhold from you the report, or part of it, if it is thought that you would be harmed by seeing it

To be completed by the Injured Person

Consent to obtain a Medical Report

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, and, in connection with an insurance claim, hereby consent to my Insurer, or any agent acting on its behalf, being provided with medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health, and I agree that a copy of this consent shall have the validity of the original.

I do not wish to see the report before it is sent to the Insurer ☐

I do wish to see the report before it is sent to the Insurer ☐

Please tick one box only

Name of Doctor	
Address of Doctor	
Name of Injured Person	
Date of Birth	
Signature of Injured Person	
Date	

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