



Personal Accident Claim Form

Once completed, please return your claim form to:

QBE European Operations
Claims
Plantation Place
30 Fenchurch Street
London
EC3M 3BD
United Kingdom

Thank you for notifying us of your claim.

Please complete this form and return to QBE as soon as possible.

Please write in **BLOCK CAPITALS**

Please provide full supporting documentation to avoid delays in processing your claim.

Please state 'N/A' where a section is not applicable.

Company Details (The Insured):

Policy Number: _____

Company Name: _____

Company Address: _____

Postcode: _____ E-mail: _____

Telephone: _____ Fax: _____

Company Contact Name: _____

Claimant Details (The Insured Person):

Title	Full Name(s)	Date of Birth	Position Held

Claimant Address: _____

Postcode: _____ E-mail: _____

Telephone: _____ Fax: _____

Country of Residence _____

Employee Number: _____



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Please provide details of your usual daily occupational duties: _____

Please provide confirmation of annual salary, including copies of 3 most recent wage slips – or – if paid weekly, please provide wage slips for 13 weeks immediately prior to the date of accident:

Please give exact time and date of accident: ____ / ____ / ____ Time: _____ AM/PM

Where did the accident occur? _____

Please describe the circumstances leading to your accident: _____

Please state injuries sustained: _____

Please provide the full name(s) and address(s) of both the attending doctor and your usual doctor (if different):

Attending Doctor:

Postcode: _____

Usual Doctor:

Postcode: _____



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When did you first seek medical attention in relation to your accident?

Date: / / Time: AM/PM

Please state:

- a) The date you ceased working: / /
- b) The date you returned to work: / /
- c) The date you intend to return to work if you are yet to do so: / /

Has the injury led to permanent disablement? YES / NO

If YES, please provide full details: _____

If you have returned to work, are you able to perform all of your duties? YES / NO

If NO, please describe the duties you can no longer perform: _____

Please state – in percentage terms – the duties you can NO LONGER perform: %

PLEASE PROVIDE FULL DETAILS OF ANY CLAIMS YOU FEEL YOU MAY HAVE UNDER THE 'ADDITIONAL PERSONAL ACCIDENT COSTS AND EXPESNSES' AND / OR 'EXTENDED PERSONAL ACCIDENT COVER' SECTIONS OF THIS POLICY



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MEDICAL QUESTIONNAIRE TO BE COMPLETED BY THE INSURED PERSON'S USUAL GP

The insured must obtain, at his / her own expense, the completion of the following certificate by a duly qualified and Registered Medical Practitioner:

Patients Name (Mr Mrs Miss Ms): _____

Please give full details of injury sustained: _____

When did the patient first obtain medical attention for this condition? / /

Please provide the date incapacity commenced: / /

Does the patient remain incapacitated? YES / NO

If YES, when is the patient expected to return to work? / /

OR, if the injury has led to permanent disablement, please provide full details: _____

If NO, what date did the patient return to work? / /

Was the patient hospitalised as a result of the injury? YES / NO

Please provide any additional details that you feel may be relevant: _____

Please complete in BLOCK capitals, and provide validation stamp:

VALIDATION STAMP

Name: _____

Address: _____

Qualifications: _____

Telephone No.: _____

Signature: _____ Date: / /

If your Claim is agreed how would you like to be paid?

If the payee name differs from the Insured name a mandate on the Insured's letter headed paper will be required before payment can be issued.

Please tick box to choose preferred method of payment.

Cheque: Confirm Payee: _____

or

Direct to your bank account: (UK bank account only)

Bank Name: _____

Branch Address: _____

Account Number: _____ Sort Code: _____

Account in the name of: _____

Declaration – This must be signed.

I/We declare that the above statements are true and correct to the best of my/our knowledge and belief. I/We have not withheld any information within my/our knowledge connected with this claim. I/We agree to provide the insurer with any further information as may be reasonably required. I/We understand that the insurer does not admit liability by issue of this form.

WARNING – the making of a fraudulent or knowingly exaggerated claim is a criminal offence. We investigate all cases and any person suspected of fraud is reported to the police, with whom we always co-operate.

The insurance industry operates a number of anti-fraud initiatives. The information on this form may be stored electronically and may be shared with other organisations for this purpose. I/We understand that you may ask for information from other organisations to check the answers I/we have provided.

Signature: _____ Date: ____ / ____ / ____