

HOSPITAL PLAN INSURANCE SERVICES

Regd. in England No. 2100356 Regd. Office - Tel: (020) 8662 8183

Please complete and return to: **ADDRESS** **HPIS, Claims Department, 96 George Street, Croydon CR9 1BU**
EMAIL **claims@hpis.co.uk**
FAX **020 8688 9202**

CLAIMANT'S NAME _____	POLICY NUMBER(S) _____
ADDRESS _____	HOME TELEPHONE NUMBER _____
POSTCODE _____	MOBILE NUMBER _____

Please FULLY COMPLETE 'Part A' of the Claim Form and 'Part C' and 'Part D' (pages 3 & 4)

PART A

Patient's full name _____ Date of birth _____

Date entered/attended hospital _____ Still in hospital on _____ Date discharged _____

Name of Hospital _____

Ward(s) _____ Give names of doctors _____

Give details of condition/reason for hospital confinement/attendance _____

Date of first symptoms _____ If childbirth - date born _____

If surgical, specify precise operation(s) performed _____

If accidental injury state when, where and how it happened _____

_____ Accident date _____

Specify any resulting fractures _____

Specify any resulting permanent disability _____

Give details of any significant illnesses or medical conditions, past and present _____

Name of patient's family doctor _____ Surgery tel. no. _____

Surgery address _____

_____ Postcode _____

You must now arrange for your GP or treating consultant to complete 'Part B' (page 2) before posting the form back to us.

Claims for Accidental death: (Note: Part B of this claim form does not need to be completed for claims under the Accidental Death benefit)

Date of death _____ Date of inquest (if applicable) _____

Full name and address of coroner (if applicable) _____

Full name and address of investigating police station (if applicable) _____

PART B – Doctor’s Statement

This section of the form must be completed by a **Doctor** (either your GP or treating consultant) to avoid delay in assessing the claim **OR** alternatively if you have hospital discharge paperwork which confirms the information below, please send this with your claim form.

Hospitalisation:

If hospitalised, what type of hospital/facility has this patient been treated in? (Please give dates spent in each category)

- Acute Hospital
- Private Hospital
- Mental Illness / Psychiatric Facility
- Long Term Nursing Unit / Nursing Home
- Rehab Centre / Hospital
- Community / Cottage Hospital
- GP Led Hospital
- Convalescence Home
- Extended Care Home
- Hospice

In-patient **Day case/A&E**

Date admitted/attended _____
 Still in-patient on _____
 Date discharged _____
 Dates of home-leave _____

Please confirm the type of treatment the patient received while an in-patient _____

Was an operation performed (including endoscopic procedures)? If yes, please provide details including dates carried out _____

Accidental Injury:

If the patient has suffered a fracture **SOLELY** due to an accident, please confirm the exact site of the fracture(s) _____

Date of the accident _____ Please specify if there is any evidence of bone disease _____

In your opinion do you think the patient will be left with a permanent disability **SOLELY** as a result of this accident? Yes No

(If yes, please provide further details) _____

Cancer Diagnosis: (Please also complete the Hospitalisation section above)

Type of cancer diagnosed (including primary and secondary) _____

Date of diagnosis _____ Date medical advice first sought _____

Please confirm whether there is any previous history of cancer (if there is, please provide full details, including date(s) of previous diagnosis) _____

Can the cancer be histologically described as pre-malignant, non-invasive, or cancer-in-situ? _____

Date radiotherapy commenced _____ Date chemotherapy commenced _____

Doctor’s Declaration: I hereby certify that my answers to the questions above are correct and true to the best of my knowledge and belief

Signature _____ **Date** _____

Print Name _____ **Title** _____

Official Hospital/GP Surgery Stamp

Access to the Medical Records Act 1988 / Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 / Access to Health Records and Reports Act 1993 (Isle of Man) ("The Acts")

To enable Hospital Plan Insurance Services to assess your claim, it may be necessary to obtain medical evidence. Any reports which are requested from your doctors are subject to the Acts. (Please note that Reports requested from Doctors appointed by Hospital Plan Insurance Services are not subject to the Acts).

In summary your statutory rights are as follows:

1. A medical report cannot be requested from any doctor who has attended to you without your written authority.
2. You do not have to give your consent. If you do consent, you can say whether you wish to see the report before it is supplied. If you do not give consent we may be unable to proceed with your claim.
3. If you say you wish to see the report, we will write to your doctor and tell them and advise you that we have done so. You will then have 21 days from the date of notification to contact the doctor to make arrangements for you to see the report.
4. The medical practitioner will be informed that you wish to have access to the report and will allow 21 days from the date of the notification for you to see and approve it before it is supplied to us. If the medical practitioner has not heard from you in writing within 21 days of the application being made, he/she will assume that you do not wish to see the report and that you consent to it being supplied.
5. If you say that you do not wish to see the report before it is sent to us, we do not need to notify you if we apply for one.
6. Whether or not you say you wish to see the report before it is sent to us, you may ask your doctor to show you a copy of the report for up to six months after it is supplied. The practitioner may charge a reasonable fee for the cost of supplying a report.
7. If you see a report before it is sent to us, the doctor cannot submit it until you give your consent. You can write to the doctor, asking that any part of the report which you consider to be incorrect or misleading be amended and to have attached to the report a statement of your views on any part where you and the doctor are not in agreement.
8. The doctor is not obliged to let you see any part of the report if;
 - a. In his/her opinion it would be likely to cause serious harm to your physical or mental health, or that of others.
 - b. It would indicate the doctor's intentions towards you.
 - c. Disclosure would be likely to reveal information relating to, or the identity of, someone else that has supplied information about you, unless that person has consented.

I hereby authorise any physician or other person who has attended or examined me to furnish the Company or its authorised representative with any and all information with respect to any illness, sickness or injury, medical history, consultation, prescriptions or treatment and copies of all Hospital or medical records.

I do do not wish to see a copy of the medical report before it is sent to the Company (please tick).

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

Signature	Date / /	Print Name
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How we use Personal Information

Your insurance is underwritten by Chartis Europe Limited. Hospital Plan Insurance Services (HPIS) is an Appointed Representative of Chartis Europe Limited and we are committed to protecting the privacy of customers, claimants and other business contacts.

"**Personal Information**" identifies and relates to you or other individuals (e.g. your dependants). By providing Personal Information you give permission for its use as described below. If you provide Personal Information about another individual, you confirm that you are authorised to provide it for use as described below.

The types of Personal Information we may collect and why - Depending on our relationship with you, Personal Information collected may include: identification and contact information, payment card and bank account, credit reference and scoring information, sensitive information about health or medical condition or criminal conviction, and other Personal Information provided by you. Personal Information may be used for the following purposes:

- Insurance administration, e.g. communications, claims processing and payment
- Assistance and advice on medical and travel matters
- Management and audit of our business operations
- Prevention, detection and investigation of crime, e.g. fraud and money laundering
- Establishment and defence of legal rights
- Legal and regulatory compliance, including compliance with laws outside your country of residence
- Monitoring and recording of telephone calls for quality, training and security purposes
- Marketing, market research and analysis

Sharing of Personal Information - For the above purposes Personal Information may be shared with our group companies, brokers and other distribution parties, insurers and reinsurers, credit reference agencies, healthcare professionals, your employer or your employer's nominated intermediary, and other service providers. Personal Information will be shared with other third parties (including government authorities) if required by law. Personal information (including details of injuries) may be recorded on claims registers shared with other insurers. We are required to register all third party claims for compensation relating to bodily injury to workers' compensation boards. We may search these registers to detect and prevent fraud or to validate your claims history or that of any other person or property likely to be involved in the policy or claim. Personal Information may be shared with prospective purchasers and purchasers, and transferred upon a sale of our company or transfer of business assets.

International transfer - Due to the global nature of our business Personal Information may be transferred to parties located in other countries, including the United States and other countries with different data protection laws than in your country of residence.

Security and retention of Personal Information – Appropriate legal and security measures are used to protect Personal Information. Our service providers are also selected carefully and required to use appropriate protective measures. Personal information will be retained for the period necessary to fulfil the purposes described above.

Requests or questions - To request access or correct inaccurate Personal Information, or to request the deletion or suppression of Personal Information, or object to its use, please e-mail: DataProtectionOfficer@chartisinsurance.com or write to Data Protection Officer, Legal Department, Chartis Europe Limited, The Chartis Building, 58 Fenchurch Street, London EC3M 4AB. More details about our use of Personal Information can be found in our full Privacy Policy at www.hpis.info/privacypolicy.html or you may request a copy using the contact details above.

Declaration and Consents

1. I declare that all statements I have made are true and complete. I consent to Hospital Plan Insurance Services or their agents undertaking any enquiries they consider necessary concerning the admission and continuation of the claim.
2. I have read and understood my statutory rights under the Access to Medical Reports Act 1988 / Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 / Access to Health Records and Reports Act 1993 (Isle of Man) ("The Acts") as outlined above and I consent to Hospital Plan Insurance Services or their agents seeking medical information, including copies of my medical records, from any doctor who at any time has attended me, concerning anything which affects my physical or mental health.
3. I have read and understood the section on the Data Protection Act 1998 and
 - I consent explicitly to Hospital Plan Insurance Services or their agents being provided with confidential information, concerning the application for this insurance, but not limited to sensitive information concerning my physical and/or mental health or condition from any third party.
 - I authorise the release of confidential information, including but not limited to sensitive information concerning my physical and / or mental health or condition obtained by Hospital Plan Insurance Services or their agents, to my doctors or any doctors or specialists appointed by Hospital Plan Insurance Services or their agents in relation to the claim and to any third party, including but not limited to my employer or my employer's nominated intermediary, who requires such information for lawful purposes.

Signature	Date / /	Print Name
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PART D

Payment of Benefits

Upon receipt of a valid claim and for your convenience, the payment will be made by transfer directly into the bank account the premiums are collected from.

If you are the 2nd, 3rd or 4th insured, we require your consent below to credit this account. Should this not be your preference, please leave this section blank. If this section remains blank, the 2nd, 3rd or 4th insured will receive a cheque rather than a direct bank transfer.

If you are the Main Policyholder (1st insured on the policy) there is no need for you complete Part D.

I am the 2nd, 3rd or 4th Insured and I consent to you crediting any amount I am due in respect of this claim directly in to the bank account the premiums are collected from

Signature	Date / /	Print Name
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