
Camberford
Underwriting
Personal
Accident
Claim Form

PERSONAL ACCIDENT CLAIM FORM

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND AS FULLY AS POSSIBLE, USING ADDITIONAL SHEETS IF NECESSARY. COPIES OF RELEVANT DOCUMENTATION SHOULD BE ATTACHED.
If you do not understand any terms in this form, please contact us for further information or visit www.camberford.com/glossary

THE INSURED

Policyholder Name:	
Policy Number:	
Occupation:	
Policyholder Address:	Post Code
Daytime Telephone Number:	
Email Address:	

Are You VAT Registered?	YES/NO

THE INJURED PERSON

Full Name:	
Occupation:	
Private Address:	Post Code
Daytime Telephone Number:	
Email Address:	
Age:	

THE EVENT					
Date and Time:					am/pm
Location:					
How did it happen?					
Was the accident witnessed by anyone else?					YES/NO
If YES, please supply the full name, address and telephone number of the person(s):					
What were you doing at the time?					
What injuries have you sustained?					
Has the same part been injured before?					YES/NO
How long have you been confined to:					
i) Bed:	From:		To:		
ii) House:	From:		To:		
How long have you been disabled from engaging in, or attending to, your usual employment or occupation as a result of the injuries?					
i) Totally:	From:		To:		
ii) Partially:	From:		To:		
Have you required medical or surgical treatment during the past five years?					YES/NO
If YES, please supply details:					

Name and Address of Doctor who is attending you:	Name: Address: Post Code	
Is he/she your normal Doctor?		YES/NO
Are you claiming under any other Insurances?		YES/NO
If YES, please supply details:		

DATA PROTECTION

HOW WE WILL USE YOUR DATA

The Basics:

Camberford Underwriting, and the underwriters with whom we arrange insurance, collect and use relevant information about you to provide you with insurance cover and to meet our legal obligations.

This information includes details such as your name, address and contact details and any other information that we collect about you in connection with the insurance cover from which you benefit. This information may include more sensitive details such as information about your health and any criminal convictions you may have.

In certain circumstances, we may need your consent to process certain categories of information about you (including sensitive details such as information about your health and any criminal convictions you may have). Where we need your consent, we will ask you for it separately. You do not have to give your consent and you may withdraw your consent at any time. However, if you do not give your consent, or you withdraw your consent, this may affect our ability to provide insurance cover and may prevent us from handling your claims.

Your information may be shared with, and used by, a number of third parties in the insurance sector for example insurers, agents or brokers, reinsurers, loss adjusters, sub-contractors, regulators, law enforcement agencies, fraud and crime prevention and detection agencies and compulsory insurance databases. We will only disclose your personal information in connection with the insurance cover that we provide and to the extent required or permitted by law.

Other people's details you provide to us:

Where you provide us or your broker with details about other people, for example employees, you must provide this notice to them.

Your rights:

You have rights in relation to the information we hold about you, including the right to access your information held by us. If you wish to exercise your rights, discuss how we use your information or request a copy of our full privacy notice, please use the contact details provided below or in our full privacy notice available at the website link below.

Want more details?

For more information about how we use your personal information and your rights please see our full privacy notice, which is available online at the following location:

www.camberford.com/privacy

Contact Details:

Camberford Underwriting
Data Protection Officer
7th Floor
Corn Exchange
55 Mark Lane
London
EC3R 7NE

DECLARATION

The submission of a fraudulent or exaggerated claim, either in whole or in part, or of any false documentation or statement in support of a Claim, may invalidate the whole claim and lead to your Policy being declared void.

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

NAME (PRINTED):	
POSITION:	
SIGNATURE:	
DATE:	

MEDICAL CERTIFICATE

THIS FORM SHOULD BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

Name of Patient:				
When were you first consulted?				
What injuries has the patient sustained from the accident?				
How long has the patient been disabled from engaging in, or attending to, usual employment or occupation as a result of the injuries?				
Totally:	From:		To:	
Partially:	From:		To:	
How much longer do you consider such disablement will continue?				
Totally:	From:		To:	
Partially:	From:		To:	
Has the patient any other disease or any previous physical defect?				YES/NO
If YES, of what nature?				
Is the present injury aggravated or caused by this?				YES/NO
If YES, to what extent may recovery be affected thereby?				

NAME:	
SIGNATURE:	
ADDRESS:	
QUALIFICATIONS:	
DATE:	