CARDIF PINNACLE
A BNP PARIBAS company

# SICKNESS CLAIM FORM (Self Employed) S

**PLEASE EMAIL YOUR CLAIM FORM TO: admin@cardifpinnacle.com**

Company Number 1007798

**IMPORTANT** POLICY TERMS MAY VARY BUT YOU SHOULD RETURN THE CLAIM FORM AS SOON AS YOU STOP WORKING. THIS WILL ASSIST THE PROMPT PROCESSING OF YOUR CLAIM

- Your copy of the Group Policy document will tell you whether you can make a claim
- Make sure you answer all the questions on this form, otherwise it will delay your claim
- Our representative might have to call on you while we are looking into your claim
- We need proof every month that you still have the disability
- Make sure that both declarations are signed before returning the form

**INSURANCE FRAUD IS A CRIMINAL OFFENCE - WE RESERVE THE RIGHT TO REFER CASES TO THE APPROPRIATE AUTHORITIES**

## A - Your Policy Details

POLICYHOLDER TO COMPLETE

Please indicate what your policy relates to: (a) Mortgage ◯ (b) Loan/Finance ◯ (c) Credit Card ◯ (d) Income Protection ◯ (e) Premium Waiver ◯

**FOR SECURITY REASONS, IF YOUR POLICY RELATES TO CREDIT CARD COVER, PLEASE DO NOT PROVIDE YOUR CREDIT CARD NUMBER AS THE POLICY NUMBER**

Policy Number

Name of Policy Provider

**If you have answered (a)-(c) above, please provide the following:**

Name of Lender, if different to Policy Provider

## B - Your Personal Details

POLICYHOLDER TO COMPLETE

Title ◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other

First Name

Date of birth / /

Surname

Address

Postcode

**In order to give you the best possible service, we may use your mobile number to call or text you and/or your e-mail address to send you updates on the progress of your claim. Please be assured neither will be used for any sales or marketing purposes or passed to any other party without your specific consent. Should you NOT wish to be sent updates through either of these methods, please tick the relevant box: SMS text ❑ E-mail ❑**

Telephone

Mobile

E-mail address

@

National Insurance Number (NI)

You can find this on: NI Card, payslips, letters from HM Revenue & Customs or from your Social Security Office

## C - Your Banking Details

POLICYHOLDER TO COMPLETE

**(Please complete this section and if your policy allows us to pay direct to your bank, we will do so. PLEASE NOTE we can not pay in to a savings account)**

Account Holder

Sort Code – –

Account Number

Bank Name

## D - Your Self Employment Details

POLICYHOLDER TO COMPLETE

What date did you start working on a Self Employed basis? / /

What date did you last work? / /

How many hours per week do you work? HRS

What is your occupation?

Why did your employment end?

What is the nature of your employment:

Sub Contractor ◯ Sole Trader ◯ Director ◯ Other ◯

If OTHER, please provide details in the box below:

Name of your Accountant

Address of your Accountant

Postcode

Accountant Telephone Number

Accountant E-mail Address

**IF YOU DO NOT HAVE AN ACCOUNTANT, PLEASE PROVIDE THE FOLLOWING EVIDENCE:**

- Please provide copies of your business bank statements for the 2 months prior to your current sickness
- Please provide copies of invoices for the 3 months prior to your current sickness

## E - Your Tax Office Details

**POLICYHOLDER TO COMPLETE**

Address of your Tax Office

Postcode

Tax Office Telephone number

Tax Office E-mail address (if known)

Your Tax Reference Number

Please give details of any benefits you have applied for from the Department of Work and Pensions (DWP) due to your current sickness

Address of your local DWP

Postcode

DWP Telephone number

## F - Sickness Claimant Section

**POLICYHOLDER TO COMPLETE**

1. Please describe the symptoms of your condition
2. What date did you last attend work? / /
3. What date did you become unable to work due to your sickness? / /
4. What date did you see your doctor for your sickness? / /
5. Has your condition been diagnosed? Yes ◯ No ◯ Unknown ◯

   If YES, please advise diagnosis
6. Date your condition was first noticed / /
7. Please give details of any investigations and treatments that you have received
8. If you are claiming for a nervous/stress related condition, other than your GP, are you seeing anyone else? If so, please attach documentary evidence to support this.
9. Have you had this condition before? Yes ◯ No ◯

   If YES, when / /

   Please give details including dates

## G - Accountant's Certificate

**(AS YOU ARE SELF EMPLOYED, PLEASE ASK YOUR ACCOUNTANT TO COMPLETE THIS SECTION)**

1. What is the Trading Name of your Client's Company?

   TO BE COMPLETED BY ACCOUNTANT
2. What is the nature of your Client's business?

   TO BE COMPLETED BY ACCOUNTANT
3. What is the address your Client trades from?

   TO BE COMPLETED BY YOUR ACCOUNTANT

   Postcode
4. What date did your Client start trading? / /
5. What date did your Client last work prior to their sickness? / /
6. How many hours a week was your client working prior to their sickness? HRS
7. Is the business still trading during your Client's absence from work? Yes ◯ No ◯
8. If YES, who is running the business in your Client's absence? (Please provide full name)

   TO BE COMPLETED BY YOUR ACCOUNTANT
9. Has your Client returned to work in any capacity since the date of disability? Yes ◯ No ◯
10. If YES, what date did your Client return to work? / /

Your Name: COMPLETED BY ACCOUNTANT

Position: COMPLETED BY ACCOUNTANT

Signature: COMPLETED BY ACCOUNTANT

Date / /

Company Stamp (if Stamp not available, **please attach a SIGNED compliment slip**)

**OMISSIONS WILL DELAY YOUR CLAIM**

EVIDENCE OF STAMP OR COMPLIMENT SLIP MUST BE PROVIDED TO VALIDATE THE CLAIM

COMPLIMENT SLIP **MUST** BE SIGNED

E-mail address: COMPLETED BY YOUR ACCOUNTANT

@

## H - Medical Certificate

**TO BE COMPLETED BY YOUR GENERAL PRACTITIONER**

**YOUR DOCTOR MAY CHARGE YOU FOR THIS, UNFORTUNATELY WE ARE UNABLE TO REIMBURSE THIS COST.**

**Please complete in BLOCK CAPITALS**

1. Patient's full name — TO BE COMPLETED BY YOUR GP
2. Patient's date of birth — / /

3. Please provide details of sickness, listing the most serious first

| Condition | Symptoms of condition | Date symptoms first present | Date patient first consulted for this condition | Does this condition wholly prevent the patient from working? |
|---|---|---|---|---|
| TO BE COMPLETED BY YOUR GENERAL PRACTITIONER | | | | Yes ◯ No ◯ |
| TO BE COMPLETED BY YOUR GENERAL PRACTITIONER | | | | Yes ◯ No ◯ |
| TO BE COMPLETED BY YOUR GENERAL PRACTITIONER | | | | Yes ◯ No ◯ |
| TO BE COMPLETED BY YOUR GENERAL PRACTITIONER | | | | Yes ◯ No ◯ |

4. Date patient first became unable to work? / /
5. What date was the illness/sickness diagnosed and by whom? / /

TO BE COMPLETED BY YOUR GP

6. Did the patient ever have symptoms, consult a medical practitioner, receive treatment or medication for this condition prior to this event? Yes ◯ No ◯

If YES, please confirm the dates and the care issued

TO BE COMPLETED BY YOUR GP

7. Was the patient hospitalised? Yes ◯ No ◯

If YES, please confirm: Date admitted / /

Date discharged / /

8. Did the patient require surgery? Yes ◯ No ◯

If YES, what was the date of the surgery? / /

9. Who performed the surgery?

TO BE COMPLETED BY YOUR GP

10. What treatment/investigations has the patient had/or are proposed, including dates?

TO BE COMPLETED BY YOUR GP

11. Are there any contributory factors that may affect a prompt return to work? If so, please advise

TO BE COMPLETED BY YOUR GP

12. Has the patient been referred to or treated by a specialist for this condition? Yes ◯ No ◯

If YES, please provide full name, speciality and date of referral

TO BE COMPLETED BY YOUR GP

13. If the patient has a psychiatric illness or nervous disorder, including stress and stress-related conditions, have they been referred for further treatment? Yes ◯ No ◯

Date patient referred for further treatment / /

Name of Assistance Programme, including Consultants positions

TO BE COMPLETED BY YOUR GP

14. In your opinion, please estimate length of recovery ___ weeks

15. Is this a current episode of a chronic condition or is your patient affected by any other long term chronic disability? please advise

TO BE COMPLETED BY YOUR GP

## GP Declaration

I certify that the patient is (or was) receiving medical attention and in my opinion is (or was) totally unable to perform any paid work during the continuous period: From / / To / /

Doctor's Name (Please print) — TO BE COMPLETED BY YOUR GP

Surgery Address — TO BE COMPLETED BY YOUR GP

Postcode

Surgery Telephone — TO BE COMPLETED BY YOUR GP

Doctor's Signature — COMPLETED BY YOUR GP

Date / /

GP Stamp (if Stamp not available, **please attach a SIGNED compliment slip**)

**OMISSIONS WILL DELAY YOUR CLAIM**

EVIDENCE OF STAMP OR COMPLIMENT SLIP MUST BE PROVIDED TO VALIDATE THE CLAIM

COMPLIMENT SLIP **MUST** BE SIGNED

## I - Medical Reports Declaration and Authority

**POLICYHOLDER TO COMPLETE**

To process your claim, we may ask your doctor to provide a medical report about you and we may also ask for copies of your medical records. In order that your doctor can provide this information, we need your signed consent to the release of medical reports and records about you. The Access to Medical Reports Act 1988 also allows you to see medical reports about you before your doctor sends them to us. Please read the summary of your rights under the Act before giving your consent and indicating if you want to see any medical report(s) about you before they are sent to us.

1. You are not obliged to allow us to see medical reports and records about you, but if you do not, we may not be able to process your claim.
2. We will let you know if we ask for a report, even if you have said that you do not want to see it.
3. If you have indicated that you want to see the report before it is sent, you must contact your doctor within 21 days of us telling you that we have requested it, otherwise your doctor may send it.
4. If you have indicated that you do not want to see the report before it is sent, you may still change your mind, but you must contact your doctor before he sends it. You may also ask for a copy of the report for up to six months after it is written.
5. You may ask your doctor to change any part of the report you consider inaccurate or misleading. If your doctor does not agree, you can still include your comments. We may refuse to consider a report containing amendments.
6. Your doctor may withhold any part of the report he considers would harm your health or undermine confidences. However, if the whole report is affected, he cannot send it without your consent.
7. We will provide your doctor with a copy of your authority to enable a report to be produced.

I authorise Cardif Pinnacle to obtain any information considered relevant from my doctor, including my medical records for the specific purpose of investigating my insurance claim.

◯ **I DO NOT want to see any medical report before it is sent to Cardif Pinnacle**

◯ **I DO want to see any medical report before it is sent to Cardif Pinnacle**

Signature YOUR SIGNATURE

Print Name PLEASE PRINT YOUR FULL NAME

Date / /

## J - Data Protection

**POLICYHOLDER TO COMPLETE**

Except as authorised in the declaration below, Cardif Pinnacle will not discuss your claim with anyone else without your permission. This includes your spouse, any other relative or friend, or your legal advisor. If you want to give us permission to talk to another person, you can authorise up to 2 people. Please provide their details below.

Please note that for your security, we will ask your authorised person to confirm their identity by confirming YOUR full name and first line of YOUR address and YOUR security password.

Security Password

**We will ask you for this password when you or your representative calls**

Title ◯ Mr ◯ Mrs ◯ Miss ◯ Ms First Name(s)

Surname Relationship

Title ◯ Mr ◯ Mrs ◯ Miss ◯ Ms First Name(s)

Surname Relationship

## K - Declaration and Authority

**POLICYHOLDER TO COMPLETE**

If you are claiming or intending to claim with any other insurer for your present sickness, then please give details of the Insurer, Policy Number and Claim Number:

| Insurer Details | Policy Number | Claim Number |
|---|---|---|
| | | |
| | | |

If you have made any previous claims against this policy, then please give details:

I declare that I have been totally prevented from doing paid work during the period given due to sickness. I declare that the statements I have made are true and agree that if they are found to be untrue Cardif Pinnacle will have the right to reclaim all claim payments made to me as a result of my dishonesty (in accordance with the policy wording).

I authorise Cardif Pinnacle and any of its agents to make any enquiries and obtain any information they may consider relevant from me, my employer(s), my doctor, any Government Body, other insurers and licensed Credit Reference Agencies who may create a record of our search.

I understand that my personal information will be held on computer or other files by Cardif Pinnacle, or its agent for the purposes of administering this insurance, including carrying out customer surveys, claims handling and fraud prevention.

I expressly agree that Cardif Pinnacle and any reinsurers collect and process data concerning my health in the event of a claim, this data being essential to the performance of my policy. I understand that I can withdraw my consent at any time. However, the withdrawal of my consent may prevent the processing of my claim and the performance of my policy. In addition the withdrawal of my consent will not terminate my policy or erase the health data collected.

I agree to my personal information being disclosed to the agent/party responsible for the sale of this insurance policy. Cardif Pinnacle will not disclose your medical information to the selling agent/party without your consent.

I understand it is my responsibility to give all necessary information to the Tax Authorities and to meet any tax demands I may have from my claim being paid.

Signature YOUR SIGNATURE

Print Name PLEASE PRINT YOUR FULL NAME

Date / /

## What to do now

**Make sure that (please tick):**

- ☐ **you have answered all the questions on the form that apply to you**
- ☐ **you have signed the form**
- ☐ **you have read the enclosed Claims Guide**
- ☐ **you have enclosed copies of your business bank statements for 2 months prior to your current sickness**
- ☐ **you have enclosed copies of invoices for 3 months prior to your current sickness**
- ☐ **you ensure that your Accountant has completed Section G, and your GP has completed Section H**
- ☐ **if you are satisfied with the content of this form, please read, sign and date BOTH the declaration and authority Sections in I and K above**

**Policy terms may vary, but you should return your claim form as soon as you stop working**

### Email everything to:

**admin@cardifpinnacle.com**

At Cardif Pinnacle, we are committed to providing you with the support you need. Visit our support site for more details: **www.support.cardifpinnacle.com**

**IMPORTANT: PLEASE BE AWARE THAT ANY CALLS YOU MAKE TO US MAY BE RECORDED FOR TRAINING AND MONITORING PURPOSES**