CARDIF PINNACLE
A BNP PARIBAS company

SICKNESS CLAIM FORM (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 Work Details

POLICYHOLDER TO COMPLETE

Name of your Employer

Telephone Number of your Employer

Email Address of your Employer (if known)

What is your job title?

What is your Work or Staff Number?

What are your usual duties?

Address of your Employer

Postcode

When did you start working there? / /

How many hours a week do you work? HRS

If you have multiple jobs, please provide the names and addresses of all your Employers, including the hours worked per week, on a separate piece of paper securely attached to this claim form.

E - Sickness Claimant Section

POLICYHOLDER TO COMPLETE

1. Please describe the symptoms which prevent you from working

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 / /
10. What is your normal occupation?
11. How does your medical illness prevent you from working in your normal occupation?

F - Employer's Certificate

TO BE COMPLETED BY YOUR EMPLOYER

1. Please confirm the full name of the person who works for you — TO BE COMPLETED BY YOUR EMPLOYER
2. Employee's occupation — TO BE COMPLETED BY YOUR EMPLOYER
3. What are their main duties? — TO BE COMPLETED BY YOUR EMPLOYER
4. What date did the Employee start working for you? / /
5. Is the employment: Temp ◯ Perm ◯ Fixed Term ◯
6. How many hours per week does the Employee work? HRS
7. What date did the Employee last work for you prior to the sickness? / /
8. Has the Employee returned to work for 16 hours or more? Yes ◯ No ◯

   If YES, on what date? / /
9. Is their job still open? Yes ◯ No ◯
10. If NO, what are the reasons?

    TO BE COMPLETED BY YOUR EMPLOYER
11. When do you expect them to return to work? / /
12. Has the employee previously suffered from this illness/ sickness whilst in your employment? Yes ◯ No ◯

    If YES, please advise dates

    TO BE COMPLETED BY YOUR EMPLOYER
13. Is there a possibility of a phased return to work? Yes ◯ No ◯

    If YES, please advise how and when this will be offered, and who will be responsible for monitoring the phased return

    TO BE COMPLETED BY YOUR EMPLOYER

Company Name — TO BE COMPLETED BY EMPLOYER

Company Address — TO BE COMPLETED BY EMPLOYER

Postcode

Telephone — EMPLOYER

E-mail address — TO BE COMPLETED BY EMPLOYER

@

Your Name — COMPLETED BY YOUR EMPLOYER

Position — COMPLETED BY YOUR EMPLOYER

Signature — COMPLETED BY YOUR EMPLOYER

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

G - 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

H - 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 / /

I - 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

J - 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 ensure that your Employer has completed Section F, and your GP has completed Section G**
- ☐ **if you have multiple jobs, you have provided the names and addresses of all your employers, including the hours worked per week on a separate piece of paper, and securely attached it to this claim form**
- ☐ **please check the form and ensure that your employers have stamped or attached a signed compliment slip**
- ☐ **if you are satisfied with the content of this form, please read, sign and date BOTH the declaration and authority Sections in H and J 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