CARDIF PINNACLE
A BNP PARIBAS company

CLAIM NUMBER

Please write your claim number in the box above

PLEASE EMAIL YOUR CLAIM FORM TO:

admin@cardifpinnacle.com

IMPORTANT

- ☐☐ / ☐☐ / ☐☐ is the earliest date that any section of this form may be filled in unless you have returned to work.
- Make sure you answer all the questions on this form, otherwise it will delay your claim.
- We may from time to time call you to confirm the details you have provided.
- Employed customers only - we will periodically write to your employer.
- All customers - it may be necessary to write to your doctor for updates on your condition.
- **INSURANCE FRAUD IS A CRIMINAL OFFENCE - WE RESERVE THE RIGHT TO REFER CASES TO THE APPROPRIATE AUTHORITIES.**

ACCIDENT & SICKNESS CONTINUING CLAIM FORM

Part A - About You (Please fill in any blank boxes)

1. Full Name:

2. Address:

Postcode

3. Home No:

4. Mobile No:

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 ❑

5. E-mail:

Part B - About Your Claim

PLEASE TAKE CARE TO ANSWER THE QUESTIONS BELOW HONESTLY AND CAREFULLY. IF YOU DO NOT, YOUR POLICY MAY BE CANCELLED, OR YOUR CLAIM REJECTED OR NOT FULLY PAID

1. What is the medical condition that is preventing you from working?

2. Has there been any changes in your condition? Please provide details below:

3. What treatment(s) are you currently receiving? Please provide details below:

Part B - About Your Claim \Continued.....

4. Other than your GP, are you seeing anyone else? If so, who, where and how regularly do you see them?

5. If you are claiming for a nervous/stress related condition, other than your GP, are you seeing anyone else, if so who, where and how regularly do you see them?

6. Please confirm the date you were last seen by a medical practitioner ☐☐ / ☐☐ / ☐☐

7. Please can you confirm if you are still being certified unfit to work by a medical practitioner Yes ◯ No ◯

8. If yes, please confirm the name and address of the medical practitioner certifying you unfit to work

   Name:

   Address:

9. Please confirm the date your fit note is signed up to (this applies to employed customers only) ☐☐ / ☐☐ / ☐☐

10. Are you still employed? Yes ◯ No ◯

11. If you are no longer employed, please confirm the date your employment finished ☐☐ / ☐☐ / ☐☐

12. If you have returned to work on a phased basis, please confirm the date and the hours you are working per week

Dates Worked		Weekly Hours Worked
From: DD / MM / YY	To: DD / MM / YY	HRS
From: DD / MM / YY	To: DD / MM / YY	HRS
From: DD / MM / YY	To: DD / MM / YY	HRS
From: DD / MM / YY	To: DD / MM / YY	HRS
From: DD / MM / YY	To: DD / MM / YY	HRS
From: DD / MM / YY	To: DD / MM / YY	HRS
From: DD / MM / YY	To: DD / MM / YY	HRS
From: DD / MM / YY	To: DD / MM / YY	HRS

◯ **Full time**

Please confirm the date you returned to work full time ☐☐ / ☐☐ / ☐☐

IF YOU HAVE RETURNED TO WORK <u>FULL TIME</u> PLEASE PROVIDE US WITH A COPY OF YOUR <u>FINAL</u> MEDICAL CERTIFICATE

Declaration and Authority

I declare that I have become disabled as defined in the policy and been totally prevented from doing any paid work during the period given (unless declared above), I declare that the statements I have made are true and agree that if they are found to be untrue, I will lose all my rights under the policy.

I authorise Cardif Pinnacle and any of its agents to make any enquiries and obtain any information they may consider relevant from me, my last or previous employer(s), my doctor, any Government Agency, Government Body, Local Authority or Tax Office.

I understand that some of my personal details (e,g address and date of birth) may be passed to these institutions for identification purposes.

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

I understand that 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 ☐☐ / ☐☐ / ☐☐