

Football Insurance Solutions



Personal Accident Insurance | Claim Form

Please complete and return this form to: A&H Claims Unit, Allianz Insurance plc, PO Box 5525, Milton Keynes, MK9 2XR – Ref No: _____

Club Details

Full Name _____ Policy Number _____
Postal Address _____

Postcode _____
Telephone Number - Home _____ Telephone Number – Work _____

Insured Details

Full Name _____ Age _____
Postal Address _____

Postcode _____
Occupation _____
Date first absent from work _____
Are you totally disabled from working? _____
When does your Doctor say you will be fit to resume work? _____
Name and Address of the Doctor who signed the attached Medical Certificate _____

Name and Address of your usual Doctor, if different from above _____

Accident Details

Date of Accident _____ Place _____
How did your accident occur? _____

What are your injuries? _____
Did you need to attend Hospital (Y/N) _____
If Yes, please enclose the Hospital In-patients Certificate
Have you ever had a similar accident before? (Y/N) _____
If Yes, give details _____

Underwritten by



Employment Details

What is your occupation _____

Please describe your duties _____

Name & Address of Employer _____

Please state average annual gross and net salary over previous 12 months from the date of the accident (please ensure you enclose a copy of your most recent payslip) or over the previous 36 months from the date of the accident. If self employed (please provide evidence of income by means of Inland revenue Tax Assessment Forms).

Gross £ _____ Net £ _____

Other Details

Are you claiming under or being paid any benefit by any other insurance or sources in respect of this disablement? _____

If 'Yes', state name and address of insurer, policy number and benefits

Access to Medical Reports Act 1988

Under the terms of this Act, you have the following rights:

- To see any report your Doctor is asked to provide for your Insurer before it is released.
- To have access to a Medical Report which has been supplied in the previous six months.
- To ask your Doctor if he/she will amend any part of the Report which you consider to be incorrect or misleading. If the Doctor is not in agreement, you may append your comments.
- To withhold your consent. But we may not be able to proceed in the absence of medical information.
- Your Doctor can withhold from you the Report, or part of it, if he/she thinks you would be harmed by seeing it.

When asking your Doctor to complete the Medical Report overleaf, please advise him/her how you wish to proceed.

Consent to Obtain Medical Report

I have been informed of my Statutory Rights under the Access to Medical Reports Act 1988, as explained overleaf and in connection with my insurance claim I hereby consent to Allianz Insurance plc seeking medical information from any Doctor who at any time has attended to me concerning anything which affects my physical or mental health and I agree that a copy of this consent shall have the validity of the original.

I wish to see the Report before it is sent to the Company (Y/N) _____

Doctor's Name _____

Doctor's Address _____

Claimants Signature _____ Date _____

Important – Please read the following carefully before signing

Data Protection Act

We may use the personal and business details you have given us or which are supplied by third parties, including any details of your directors, officers, partners and employees whose consent you must obtain to allow us to provide you with a quotation; deal with your policy; to search credit and fraud reference agencies who may keep a record of the search; to share with other insurance organisations to help offset risks, to help administer your policy and to handle claims and prevent fraud; to support the development of our business by including your details in customer surveys, and for market research and compliance business reviews which may be carried out by third parties acting on our behalf. We may need to collect data relating to Insured Persons, which under the Data Protection Act is defined as sensitive (such as medical history of Insured Persons) for the purpose of evaluating the risk or administering claims which may occur. By signing this form you consent to such information being processed by us. You must also ensure that you make this fact known to the Insured Persons and obtain their explicit prior consent to pass this information to us for these purposes. We may share your details with other companies within the Allianz group of companies or pass them to third parties so that we may tell you by telephone, email or post of products and services which we think may be of interest to you. If you do not want to know about these products and services, please write to: Customer Satisfaction Manager, Allianz Insurance plc, 57 Ladymead, Guildford, Surrey, GU1 1DB to let us know. Your details will not be kept for longer than is necessary. Under the Data Protection Act 1998 individuals are entitled to a copy of all the personal information Allianz Insurance plc holds about them. Please contact the Customer Satisfaction Manager at the address above. Personal details may be transferred to countries outside the EEA. They will at all times be held securely and handled with the utmost care in accordance with all principles of English law.

VERY IMPORTANT – Fraudulent and Exaggerated Claims

Deliberately exaggerated claims could invalidate your Policy cover. Insurance fraud is a crime, liable to prosecution. The above answers to our questions will be the basis of consideration of your claims. You must ensure that all information is true and correct to the best of your knowledge and belief, and that all material facts have been disclosed. A material fact is one that is likely to influence us in the assessment or acceptance of this claim, or one that is likely to influence our consideration of cover under terms of your policy. If you are in any doubt as to whether a fact is material, you must disclose it.

FAILURE TO DO THIS MAY MEAN THAT YOUR POLICY BECOMES INVALID AND A CLAIM PAYMENT WILL NOT BE MADE.

Signature (required for all claims)

I declare the foregoing particulars to be correct to the best of my knowledge and belief.

Signature of claimants _____ Date _____

Signature of club official _____ Date _____

Position of club official _____

Contact Details of club official _____

Postal Address _____

_____ Postcode _____

Telephone Number _____

Please complete and return this form to: A&H Claims Unit, Allianz Insurance plc, PO Box 5525, Milton Keynes, MK9 2XR

Medical Report

To be completed by the insured person's medical attendant:

This is to certify that _____

is suffering from _____

and will probably be unfit to resume work until _____

If the disablement is only partial, please state when resumption of full duties should be possible _____

Disablement from engaging in or attending to usual business or occupation commenced on _____

If a definite/estimated date of return to work can be given, please complete the following _____

Total disablement from _____ To _____

On the basis of your existing knowledge and without undertaking any further examination, is it your opinion that the disablement indicated above is solely attributable to the specific illness or injury sustained? (Y/N) _____

If no, state other contributory factors and the extent to which disablement is thereby affected _____

Has the patient been attended or treated for this condition or had a related diagnosis? (Y/N) _____

If yes, please provide details _____

Have you previously attended the patient? (Y/N) _____

If Yes, for what purposes and on what dates _____

Are you the patient's usual medical attendant? (Y/N) _____

Signature of Medical Attendant _____ Date _____

Qualifications _____

Postal Address _____

_____ Postcode _____
