ACCIDENT / SICKNESS CLAIM FORM

Claimant/Patient: **Date of Birth:**

Policy number: **Claim Number:**

When completed this form should be returned to;
The Claims Manager, Cigna Insurance Services, 1 Drake Circus, Plymouth, PL1 1QH.

SECTION 1. DECLARATION AND CONSENT TO BE SIGNED BY CLAIMANT / PATIENT

I confirm that my Doctor may complete this claim form and provide any knowledge or information to Cigna to enable Cigna to determine the validity of my claim under the above policy. I agree and accept that Cigna and its agents may provide and receive from other claims administrators or insurers any information required to process and validate my claim.

If Cigna subsequently requires a medical report in connection with my claim I confirm that any Doctor, who at any time has attended me concerning anything which affects my physical or mental health, may provide a medical report including relevant medical information to Cigna and its Professional and Medical Advisors. I agree that a copy of this consent shall have the validity of the original. I have been advised of my statutory rights in a separate note.

1. If a Medical Report is subsequently requested do you wish to see the report before it is sent to Cigna? Yes ☐ No ☐

   Claimants Signature _____ Date / /

2. If a joint policy I have attached copy wage slips for both policyholders for the two month period prior to the claim date. Tick to confirm ☐
3. Have you returned to work? Yes ☐ No ☐

   3a. If **'Yes'** on what date? / /

SECTION 2. INFORMATION TO BE COMPLETED BY THE DOCTOR (any fee is the responsibility of the patient)

4. Give a brief description of the nature of the injuries or illness
   (include any reference to complications of pregnancy / childbirth, drugs or alcohol taken without medical advice)

5. When did you first sign off the patient as unfit for work? / /
6. Does the patient remain unfit for work and signed off? Yes ☐ No ☐

   6a. If **'No'** when did you last sign the patient as fit for work? / /

   6b. If **'Yes'** was this period continuous? Yes ☐ No ☐

   6c. Latest medical certificate From / / To / /

   6d. Likely return to work date? / /

7. Was this period of certified sickness a result of any of the following:
   a) Normal pregnancy / childbirth? Yes ☐ No ☐
   b) Intentional self inflicted injuries? Yes ☐ No ☐
   c) Taking drugs or alcohol unless on medical advice? Yes ☐ No ☐
8. Was the patient hospitalised due to the accident or illness? Yes ☐ No ☐

   8a. If **'Yes'** over what period From / / To / /

9. If an illness, please advise:

   9a. The date on which you were first consulted / /

   9b. The date on which the illness was first diagnosed / /

   9c. Has the claimant suffered with this or any related condition previously? Yes ☐ No ☐

   If **'Yes'**, please advise the dates and duration of the previous episodes.

SECTION 3. TO BE SIGNED BY THE DOCTOR

Doctor's Signature

Tel No

GMC Number Date / /

Official Stamp

2008010000000000156312 10080100000000000111106 DT42

This insurance policy is administered by Cigna Insurance Services, which is a trading style of Cigna Insurance Services (Europe) Limited. Cigna Insurance Services (Europe) Limited is registered in England & Wales No. 4617110. Registered Office: Chancery House, St Nicholas Way, Sutton, Surrey SM1 1JB. Cigna Insurance Services (Europe) Limited is authorised and regulated by the Financial Conduct Authority.