RISK ASSURANCE MANAGEMENT

LANCASHIRE POLICE
CRITICAL ILLNESS BENEFIT CLAIM FORM

Serving Member ☐ **Child** ☐

Full Name: (Mr/Mrs/Miss/Ms) ……

Address: ……

……

Telephone/ Mobile Number: ……

Email: ……

Date of Birth: ……..

Serving Members Collar/Payroll Number: ……

Serving Member's Full Name: (for Child claims) ……

Serving Member's Date of Birth: (for Child claims) ……

1. Please describe your condition in full (continue on a separate sheet if required):

……

……

2. On what date did you first note symptoms?

……

3. On what date was your condition diagnosed?

……..

Chancery House, Leas Road,
Guildford, Surrey GU1 4QW
Tel: 0370 7200 780 Fax: 0370 7200 781
Email: group.risk@ram-ltd.co.uk Web: www.ram-ltd.co.uk

Risk Assurance Management Limited, insurances arranged at Lloyd's
Risk Assurance Management Limited is authorised and regulated by the Financial Conduct Authority
Registered Address: 35 Lavant Street, Petersfield, Hampshire GU32 3EL
Registered in England and Wales No: 1334065

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4. Please provide full details including dates of any tests/investigations which have been carried out (please provide name, department, reference (if appropriate) and address of the institution where such tests were performed):

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5. What treatment are you currently receiving?

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6. Have you previously suffered from the same or any similar condition? Please provide full details including dates:

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7. Please provide the name and address of your General Practitioner:

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8. When did you first consult your General Practitioner for this condition?

……

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9. Please provide the name and address of the doctor(s)/specialist(s) consulted for this condition, or details of hospitalisation. Please indicate who would be the most appropriate to contact:

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10. Please provide details of any other insurance policies under which you may receive payment for this condition:

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11. Please provide any further details you feel may help us when assessing your claim:

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12. Have you previously made a claim under a Critical Illness Policy? If yes, please provide full details:

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……

I certify that the answers and statements provided above are full and true to the best of my knowledge and belief and that I have not withheld any material fact from Risk Assurance Management Limited.

Member's signature:

Full Name:

Date:

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Access to Medical Reports Act 1988

Your rights under this Act – please read this carefully

a) You do not have to agree to a medical report
b) You can see the report before your doctor sends it to us, or during the six months after that.
c) You can ask the doctor to change any of the report if you think it is wrong or misleading. If the doctor does not agree, you can write your comments on a sheet of paper and attach them to the report.
d) If you ask your doctor for a copy of the report, you might have to pay for it. The doctor does not have to show you parts of the report which:
    - Might damage your, or anyone else's physical or mental health.
    - Would give away the doctors intentions for treating you; or
    - Would tell you about someone who has given information about you. (This does not apply if that person agrees to you knowing or is a health worker looking after you)

The doctor must tell you if he or she has not shown you part of the report. If the whole of the report is affected, your doctor must not send it to us unless you agree.

If you tell us you want to see the reports before your doctor sends them to us, your doctor must show them to you first unless you fail to arrange to see them within 21 days.

Please tick one box

I wish to see reports before they are sent to the Company. ☐

I do not wish to see reports before they are sent to the Company. ☐

Settlement of this claim will be made by electronic transfer to the Member:-

Member's Bank Details:	
Bank Account Name:	……..
Bank Account Number:	……..
Bank Sort Code:	……..
Bank Name:	……..
Bank Address:	……...
	……...

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Data Protection

I understand that the use of any information provided by me for the operation of this insurance is for the process of underwriting, administration, claims management, handling customer concerns and the detection, prevention and investigation of fraud.

I understand that in order to do this the information may be shared with other insurers, reinsurers, insurance intermediaries and service providers who are involved in either the operation of insurance which covers members or the member's benefits arrangements provided by the Company in accordance with the Data Privacy Notice shown on our website: www.ram-ltd.co.uk.

I understand the data will be processed fairly and securely and the details will be stored on computer but will not be kept longer than necessary.

I understand that the data I have provided in relation to this insurance will be processed in accordance with the requirements of the General Data Protection Regulation.

Declaration

I hereby certify that the information provided is true and correct and I agree that any statement made by me and found by Risk Assurance Management Limited to be false shall surrender all my rights under my policy at the option of the company.

I hereby authorise any hospital, physician, employer or any other person to furnish all information as requested by the company or its representative in consideration of the claim.

Copies of this declaration will be legally valid.

I confirm I have read and understood the information in this claim form including the section relating to:

- Access to Medical Reports Act 1988
- Data Protection
- The Declaration

I understand that Risk Assurance Management Ltd may ask other insurers for information to check the information I have given.

Claimant's signature:
Full Name:
Full Address (including postcode):
Date:

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Trustees Declaration

We hereby apply to Risk Assurance Management Limited for payment of the Critical Illness Benefit claimed. We declare that the claimant is a Member of the Scheme and paying premiums up to the date of diagnosis and the particulars provided are correct to our knowledge and belief. We confirm that payment of this claim will discharge all liability in respect of this Member under this Contract for the illness upon which the claim was settled and such related illnesses decided on by the Company.

TO BE COMPLETED BY THE TRUSTEES

Critical Illness benefit amount being claimed (£):

Date Claimant joined the Scheme: / / (dd/mm/yyyy)

Date Serving Member joined the Force / / (dd/mm/yyyy)

Date last day Actively At Work **:** / / (dd/mm/yyyy)
(Serving Members only)

Authorised Signature:

Title:

This form must be signed by a duly authorised person of the Trustees.

Print Name:

On Behalf of:

Date: / / (dd/mm/yyyy)

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