PERSONAL ACCIDENT CLAIM FORM

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It is important that all relevant sections of the claim form are completed. Failure to provide us with all required information and documentation may delay the processing and settlement of your claim.

Please post your completed claim form to us at:

California
120, Coombe Lane
Raynes Park
London SW20 0BA

FOR OFFICE USE ONLY
Date received:
Payroll no:
Confirmation:

Please complete Claim Form in **BLOCK Capitals** in blue or black ink.

To be completed by the claimant or by an other person on belhalf of the claimant

Section A: Claimant's Details

Title:
Name:
Surname:

Address:

Contact Number (including STD code):

Tel (home):
Tel (work):
Mobile:

Date of Birth:_____/_____/_____

Payroll number:
Occupation:

Email address:

Section B: Claimant's Injury

Nature of injury:

Where did the accident occur?

When did the accident occur?

Date:____/____/____ Time:_____

How did the accident occur?

When did you return to work or when do you anticipate being able to return to work?

Please tick box for what you are claiming for.

☐	1	Accidental Death
		Disablement
☐	2a	Loss of two or more limbs or sight in both eyes or one of each
☐	2b	Loss of one limb or sight in one eye
☐	2c	Loss of speech
☐	2d	Loss of hearing in both ears
☐	2e	Loss of hearing in one ear
☐	3	Permanent total disablement from usual occupation
	4	Permanent Disability
	4a	Senses and Faculties
☐	i	Total loss of sight of one eye
☐	ii	Total deafness of both ears
☐	iii	Total deafnes of one ear
☐	iv	Total loss of speech
☐	v	Total loss of sense of taste and smell
	4b	Face and Skull
☐	i	Loss of whole of lower jaw
☐	ii	Loss of facial tissue, incapable of surgical reinstatement and necessitating permanent use of cosmetic mask
☐	iii	Loss of facial tissue, partially capable of surgical reinstatement but with poor cosmetic results
	iv	Loss of bony substance of the skull in all its thickness:
☐	a	6 sq cm
☐	b	3 sq cm
	v	Prominently raised facial scarring totalling:
☐	a	15cm in length or 15 sq cm in area
☐	b	5cm in length or 5 sq cm in area
	4c	Bodily Organs and Spinal Column
☐	i	Loss of one kidney
☐	ii	Loss of whole of one lung
☐	iii	Severe loss of spinal strenght and mobility substantially and continuously restricting normal day to day domestic activity
☐	iv	Partial loss of spinal strenght and mobility with continuous pain during normal day to day domestic activity

Continued…

	4d	Upper Limbs
☐	i	Loss of one arm or one hand
☐	ii	Complete immobility of shoulder
	iii	Complete immobility of elbow
☐	a	in unfavourable position
☐	b	in favourable position (within 15 degrees of right angle)
	iv	Complete immobility of wrist
☐	a	in awkward position
☐	b	in straight position
☐	v	Total loss of thumb
☐	vi	Partial loss of thumb - one phalange
☐	vii	Complete immobility of thumb
☐	viii	Total loss of forefinger
	ix	Partial loss of forefinger
☐	a	two phalanges
☐	b	one phalange
☐	x	Total loss of any other finger
	4e	Lower Limbs
☐	i	Loss of leg at or above the knee
☐	ii	Loss of leg below the knee
☐	iii	Loss of foot at or above the ankle joint
☐	iv	Loss of half of foot
☐	v	Complete immobility of hip
☐	vi	Complete immobility of the knee
☐	vii	Total or partial loss of kneecap with considerable restricted movement
☐	viii	Total or partial loss of kneecap with full movement preserved
	ix	Shortening of lower limb:
☐	a	by 5cm or more
☐	b	by 3 to 5cm
☐	c	by less than 3cm
☐	x	Loss of big toe
☐	xi	Complete immobility of big toe
☐	xii	Loss of any other toe
☐	5	Quadriplegia
☐	6	Triplegia
☐	7	Hemiplegia

☐	8	Paraplegia

Section C: Claimant's Declaration

I hereby declare that I am the person referred to in the preceding pages and that I have read the replies to all of the questions on this form and that to the best of my knowledge and belief the information is true and I have not withheld any material facts.

I consent to the information contained in this form I understand that this may involve Canopius Underwriting discussing this claim with my employer and I consent to Canopius Underwrting passing the Personal Data to my employer, its professional advisers and any other person involved in the assessment of the claim.

I consent to you seeking information in connection with this claim from any doctor who has at any time attended me, or any relevant person, and I authorise the provision of such information, together with hospital and General Practitioner's notes.

I do not require to see any medical reports before it is used. ☐ Yes ☐ No

Please provide details of the General Practitioner.

Name:	Address:

Signature of the claimant: _____ Date: _____/_____/_____

If you are unable to sign the declaration, please obtain a signature on your behalf below: Signed on behalf of claimant: _____ Date: _____/_____/_____	
Name:	Relationship to claimant:

Section D: Data Protection Notice

For policy administration purposes, Canopius will use and store the information you provide in this claim form on an electronic database, which may also be available to selected authorised representatives of member insurers of Canopius Underwriting operating outside Europe. Canopius has taken responsible measures to protect your information. Canopius may also disclose your information to outside parties such as re-insurers, to provide the insurance and claims services to you, or as allowed by law.

By signing this claim form, you concent to Canopius's use of this information in the manner and for the purposes described above.

I certify that the statements I have made in this claim form are correct. I consent to the seeking of information from other insurers to check the answers I have provided and I authorise the giving of such information.

Signature: _____ Date: _____/_____/_____

Section E: Registered Medical Practioner Certificate

To be completed by the claimant's Medical Practioner.

When did you first attend on the claimant in respect of the injuries sustained in this accident?

Are you still in attendence?	☐ Yes ☐ No

Are you the usual Medical Attendant of the claimant?	☐ Yes ☐ No
If yes, how long have you known him/her?	

Please give full details of the injuries.

Is there anything in the claimant's medical history which may have contributed directly or indirectly to the current injury?

General remarks:

Declaration

I certify that the foregoing statements are correct to the best of my knowledge and belief.

Address:

OFFICIAL STAMP

Signature: _____

Date: _____/_____/_____