Personal Accident

In order to support the process of your Personal Accident Claim, we have put together a checklist to ensure you include the correct paperwork to support your claim. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

Please be aware that you can only make a claim under Personal Accident in the event of death, paralysis, loss of limb or loss of sight, there are no benefits payable for any other injury.

Your Checklist of Documents Required

Please Note: We do not require original receipts, passports, EHIC's, death certificates or CD's for the initial claims set up, a top tip is to take a clear photo of your receipts and email them over to us.

Please ensure you keep the originals safe in case we do still require them.

No need to staple your papers either; the full contents of each envelope we receive are immediately scanned onto our computer system, and having to remove staples may damage the papers which could delay your claim!

In the event of a death:

- ☐ A copy of the original death certificate and if applicable the coroner's report
- ☐ Letters of administration or Grant of Probate
- ☐ A copy of any accident reports or police incident reports
- ☐ Copies of any medical reports

In the event of paralysis, loss of limb, or loss of sight:

- ☐ A completed medical certificate by the general practitioner (GP) or consultant of the person claiming (this can be found in the below form)
- ☐ Copies of any medical reports

Please consider the environment before printing this checklist. We **do not** require the checklist to be printed and returned.

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Personal Accident

Email: claims@tifgroup.co.uk
Post: tifgroup Claims, 1 Tower View, Kings Hill, West Malling, Kent, ME19 4UY

Top Tip: If you tap or click the box you can type away & email your claims form with the relevant documents to us.

Claims Reference Number, if already known:	

Details of the Claimant

Title:		First Name:		Last Name:	
Address:					
Post Code:		Email Address:			
Date of Birth:	DD/MM/YYYY	Telephone:			
Bank Name:		Name on Account:			
Account Number:		Account Type: (e.g. premier, gold, reward)			
Sort Code:		SWIFT/BIC (for payments outside of the UK)			
IBAN (International Bank Account Number):					

For your convenience and to offer an efficient smoother service, we will pay any claim settlement due directly into your bank account. *We do not accept liability for any payment misdirection or delay due to the incorrect bank details being provided by you.*

Details of the Insurance Policy and Trip

Policy Number:		Date of Issue:	DD/MM/YYYY
Insurance Company Name:		Date Trip Booked:	DD/MM/YYYY
Policy Cover Level (e.g. silver, gold, standard etc.)		Destination:	
Trip Date From:	DD/MM/YYYY	To:	DD/MM/YYYY
Do you or any of the insured party have any other travel insurance cover? If yes give details.			

Details of Claim

Please be aware that you can only make a claim under Personal Accident in the event of death, paralysis, loss of limb or loss of sight, there are no benefits payable for any other injury.

Were tifgroup-assistance contacted for advice?		Yes: ☐	No: ☐
When was the first time they were called?	DD/MM/YYYY		
Reference number given:			
What was the name of the person handling the case?			
Has a claim for medical expenses been submitted?		Yes: ☐	No: ☐
If **yes**, what is the claims number?			

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Date Incident Happened:	DD/MM/YYYY	Time of Incident:	HH:MM	AM:		PM:	
Where did the accident occur?							
Hospital/Clinic treated in? (please include name of hospital or clinic)							
What was the name of the treating doctor?							
What injuries were sustained? (please include details such as right/left leg or arm etc.)							

Please describe in detail the circumstances leading up to this accident. Please try to include dates and times. You should give as much information as possible – if any other people were involved in the accident or witnessed it, please provide their names and contact details

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Claim Declaration

- I/We declare that all the details provided above are true and accurate to best of my knowledge.
- I/We give consent for tifgroup to seek recovery of monies paid where other insurers cover the same risk, or from third parties who may be held liable.
- I/We understand that details of this claim may be passed to the insurance industries central claim register
- I/We understand that if a claim is found to be fraudulent or exaggerated that this will invalidate the whole claim and tifgroup may seek to recover any costs through the civil courts.
- I/We understand that where a claim or claims are made on behalf of others, I have their full authority to act on their behalf, and I confirm that I understand that neither tifgroup or the underwriters of the policy will accept the responsibility if any payments are not distributed proportionately to the persons concerned.

Signature:		Date:	DD/MM/YYYY
Print Name:			

Consent

I give my authority for you to communicate with the following people who I may wish to contact you, or to be a point of contact for me, whilst my claim is being finalised.

Full Name:	
Full Name:	

Your Signature:		Date:	DD/MM/YYYY

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Medical Certificate

This medical certificate is to be completed by the General Practitioner of the person whose injury caused this claim. *NOTE: Any charges for completion of this form are the responsibility of the claimant.*

Policy Number:				
Doctors Name:		Doctors Qualification:		
Signature:			Date:	DD/MM/YYYY
Surgery Stamp:			Telephone:	

Please answer ALL questions in full. (N/A or dashes are not acceptable).

Patients Name:		Date of Birth:	DD/MM/YYYY
Address:		Post Code:	

Has the patient suffered from permanent and total loss of or loss of use of any of the following?						
Hand:	Left: ☐	Right: ☐			If yes, date:	DD/MM/YYYY
Foot:	Left: ☐	Right: ☐			If yes, date:	DD/MM/YYYY
Sight in one or both eyes:	Left: ☐	Right: ☐	Both: ☐		If yes, date:	DD/MM/YYYY

Has the patient suffered from permanent and total disablement preventing them from engaging in any paid employment or paid occupations?			
Yes: ☐	No: ☐	If yes, date:	DD/MM/YYYY

Please describe the nature of the accident that led to the injury referenced above:	
What date did the accident occur?	DD/MM/YYYY
What date where you first consulted?	DD/MM/YYYY
Did the patient have any existing medical problems at the time of the accident that could have contributed to the cause of the injury, the extent of it, or their ability to recover? If so, please describe the nature of the existing problems and how they have contributed:	

Was the patient referred to a consultant?	Yes: ☐	No: ☐
Date seen by consultant:	DD/MM/YYYY	

If yes, please advise the consultants name, title and hospital address:

Consultant Name:			
Address:		Post Code:	

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Access to Medical Reports Act 1988

We at tifgroup are acting agents on behalf of your insurer, full details are listed within your policy document, if we require information from your Doctor in respect of your claim you have certain rights under the Access to Medical Reports Act 1988: -

- Your consent* is required before the insurer or anyone acting as their agent can apply for a report and you may see the report before it is supplied to the insurer or their agents, or at any time during the six months after that.
- If you disagree with the contents of the report or consider it to be misleading you may ask your Doctor to amend it. If the Doctor disagrees you may add your own written comments. The Doctor may withhold all or part of the report from you if he/she thinks that this would be in your best interests, or that of others. Alternatively, you can refuse to give your consent*.
- At no time will the report be sent to the insurer or anyone acting as their agent without your consent.

*You can refuse to give your consent however this may mean we are unable to deal with your claim

Charges made by the Doctor for providing such a report are your responsibility, as they are not covered by this policy.

Details of the Patients/ Your Usual General Practioner

Patient Name:			
Name of General Practioner:			
Surgery Address:		Post code:	
Telephone number:			
Name of hospital admitted to (if applicable)			
Consultant Name:			

Declaration

I consent to tifgroup or anyone acting as agents for the insurer as detailed within the policy documents, seeking medical information from any doctor who has at any time attended me concerning anything which affects my/the patient's physical and/or medical health. I authorise the giving of such information during and after my lifetime. I have been informed of and understand my rights under Access to Medical Reports Act 1988 (see above).

I do/ do not wish to see any report before it is sent:	I do		I do not	

Patient's Details

Title:		First Name:		Last Name:	
Address:					
Post Code:					

Signature of patient or next of kin:		Date:	DD/MM/YYYY
Print Name:			
If next of kin, please advise your relationship:			

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