



Terminal Prognosis Advance Payment

CLAIM FORM

Serving Member

Spouse/Partner of
Serving Member

Retired Member

Spouse/Partner of
Retired Member

(Please tick accordingly)

Full Name: (Mr/Mrs/Miss/Ms)

Address:

.....

.....

Telephone Number:

Mobile Number:

Date of Birth:

Officer's Full Name:

Officer's Date of Birth:

(for Spouse/Partner Claims)

Scheme Name:

Policy Number:

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

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2. On what date did you first note symptoms?

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3. On what date was your condition/illness diagnosed as terminal?

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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 to include dates:

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

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<p>8. When did you first consult your General Practitioner for this condition?</p> <p>.....</p> <p>.....</p>
<p>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:</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>10. Please provide any further details you feel may help us when assessing your claim:</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

<p>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.</p>
<p>Claimant's signature:</p>
<p>Full Name:</p>
<p>Date:</p>



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.

Data Protection Act 1998

I understand and consent to the use of any information provided by me for the operation of this insurance. This includes the process of underwriting, administration, claims management, rehabilitation and handling customer concerns.

I understand that in order to do this the information may be shared with other insurers, re-insurers, insurance intermediaries and service providers who are involved in either the operation of insurance, which covers member or the member's benefits arrangements provided by the company.

I understand the data will be processed fairly and securely in accordance with the Data Protection Act 1998 and the details will be stored on computer, but will not be kept for longer than necessary.

I confirm that the data in relation to this insurance has been obtained and passed to:
Risk Assurance Management Limited in accordance with the requirements of the Data Protection Act 1998.



Declaration

I hereby certify that the foregoing information 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 understand that this form will be passed to *or used by member companies of: Risk Assurance Management Limited for the purpose of my insurance.* This includes underwriting, processing, claims handling and fraud prevention, which could include passing details to agents of Risk Assurance Management Limited or other insurers. You may ask other insurers for information to check the information I have given.

Claimant's signature:

Full Name:

Full Address (including postcode):

Date:

