

BMW Critical Illness Claim Form



IMPORTANT INFORMATION WHEN MAKING A CLAIM

Incomplete claim forms may cause delay in the assessment of your claim.

You must provide any other details we request that relates to your claim before we will consider any payments.

All costs incurred to submit this claim are the responsibility of the claimant.

Premiums must continue to be paid on the due date while you are in a claim situation if you require continuous cover.

One of our appointed representatives may visit you during your claim. Failure to see them could invalidate or seriously delay your claim.

If you qualify for any State Benefit, you should advise the Department for Work and Pensions if you are claiming under this policy. The amount of monthly benefit you receive under this policy may effect your entitlement to State Benefit. The Department for Work and Pensions will be able to provide you with all the details.

Please note that this insurance is underwritten by Allianz Insurance PLC who are authorised and regulated by the Financial Services Authority (FSA).

This insurance product is administrated by Mondial Assistance Limited who are authorised and regulated by the Financial Services Authority (FSA). Mondial Assistance (UK) Limited will act as agent for Allianz with respect to claims process.

Please note that all calls are recorded for accuracy and training purposes.

We recommend that you send your claim documents by recorded delivery.

Return your completed claim forms as soon as possible in order for us to progress your claim as quickly as we can. Return forms to Claims Department, BMW Protect Services, PO Box 1852, Croydon, CR9 1PW.

We strongly recommend that you keep copies of your completed claim form and all other supporting documents.

BMW Critical Illness Claim Form - Please Complete in Block Capitals

POLICYHOLDER DETAILS (TO BE COMPLETED BY CLAIMANT)

Policy Number

Title

Last Name First Name(s)

Address

Post Code

Home Telephone Number

Mobile Telephone Number

Email Address

Would you like to be contacted via email in relation to your claim?

Date of Birth National Insurance Number

Do you have any other income protection or payment protection insurances?

If yes, please attach name, address and telephone number of insurer and the monthly benefit amount.

EMPLOYMENT DETAILS (TO BE COMPLETED BY CLAIMANT)

Please give details of your employment history for the previous 12 months prior to your illness.

Name, address and telephone number of employer	Dates		Type of employment Permanent, Temporary, Self Employed
	From	To	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

What is your grossed earned yearly income?

What date did you last work?

What date did your illness start?

What is the nature of the illness?

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DETAILS CONTINUED (TO BE COMPLETED BY CLAIMANT)

Have you previously suffered from this or any related condition?

If yes, please give dates and details

From

To

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Please give the name, address and telephone number of your usual doctor.

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Postcode

Telephone number

Please give the name, address and telephone number of your Department of Work and Pensions office from which you are claiming benefit.

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Postcode

Telephone number

POLICYHOLDER BANK ACCOUNT DETAILS (TO BE COMPLETED BY CLAIMANT)

Please give Bank Account details, for the purpose of benefit payments.

Account Number

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Sort Code Number

--	--	--	--	--	--	--	--

Please give the name and address of your Bank or Building Society.

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Postcode

IF YOU WOULD LIKE SOMEONE ELSE TO DEAL WITH YOUR CLAIM ON YOUR BEHALF THEN PLEASE GIVE THE FOLLOWING DETAILS.

Title

First Name(s)

Last Name

Date of Birth

Relationship to you

I hereby consent to any information being given about my claim to the above named person.

Signed

Date

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EMPLOYMENT DETAILS (TO BE COMPLETED BY EMPLOYER/CONTRACTOR)

Employment start date

Employment end date, if applicable

How many hours is the employee contracted to work per week?

Please state if employment was permanent, temporary, for a fixed term, seasonal or other.

Is the employee working on a fixed term contract, if so please give details.

Dates of contract

From

To

Was the contract renewed?

How many times?

What is the employee's job title immediately prior to being unable to work?

What is the nature of the illness that is preventing the employee from working?

Please give dates of present illness.

From

To

Please give details of the employee's absence due to illness over the last 12 months.

From

To

Nature of illness

From	To	Nature of illness
<input type="text"/>	<input type="text"/>	<input type="text"/>

Signed

Company Stamp

Please print name

Position Held

Date

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MEDICAL CONSENT (TO BE COMPLETED BY CLAIMANT)

ACCESS TO MEDICAL REPORTS ACT 1988 - EXPLANATION

It is important you read the following information as we may need to obtain medical reports in order to assess your claim. Before we approach your doctor we need your consent under the Access to Medical Reports Act 1988. Your rights under the Act are as follows:

You do not need to give your consent, however if you do not, we may not be able to consider your claim. This does not prevent you from applying to other insurance companies.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report in this time, your doctor will send the report to us.

If you choose not to see the report at this stage, you may ask your doctor for a copy within six months of it being sent to us. We can send a copy of the report to your doctor if you ask to see it at a later date.

If you believe that any part of the report is not correct or is misleading, you may ask your doctor to amend it. If your doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will accompany the report.

Your doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

CONSENT TO OBTAIN MEDICAL REPORT

Please make sure you have read the above rights before you complete and sign the consent below. I have been informed of my statutory rights under the Access to Medical Reports Act 1988 as explained above and in connection with my insurance claim. I consent to my insurer Allianz Insurance PLC, working on behalf of BMW Financial Services, being provided with medical information, including a copy of my medical notes and consultant reports from any doctor who at any time has attended me concerning anything which affects my physical or mental health, and I agree that a copy of this consent shall have the validity of the original.

I WISH TO SEE THE MEDICAL REPORT, please tick as appropriate YES NO

Signed Date

Please print name

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MEDICAL DETAILS (TO BE COMPLETED BY YOUR DOCTOR)

What is the nature of the patients illness?

When did the patient first consult you for this condition?

When was the condition first diagnosed?

Has the patient consulted you with any symptoms related to this condition in the last 5 years?

If "yes" please give details including dates consulted.

From To Details

From	To	Details
<input type="text"/>	<input type="text"/>	<input type="text"/>

Please confirm the dates totally unfit for all work?

From

To

Is the patient still unfit for work?

If "yes" please give an estimated return to work date.

Please give details and types of treatment provided for the current illness.

Please provide a current prognosis for the patients condition.

If the patient has been referred please give the name and address of consultant.

Is the condition due to pregnancy?

Is the condition due to self-inflicted injury, consumption of alcohol, or taking of drugs other than under medical advice?

If "yes" please give details.

I certify that this patient is under medical attention.

Signed

Doctor's stamp

Please print name

Telephone number

Date

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CRITICAL ILLNESS CLAIM FORM CHECKLIST

Please check you have included all the requested information.

Have you completed all parts of your personal and employers details?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If self employed or a contract worker have all relevant documentation been included?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has your employer completed the form attached?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has your doctor completed the form attached?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you included a copy of your P60 or last tax assessment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

APPLICATION DECLARATION

I hereby declare that all information supplied is true in every respect to the best of my knowledge and belief and that I have disclosed all additional information likely to influence the assessment of my claim. I consent to the seeking of information from any person/organisation as deemed necessary by the insurers to verify the answers provided.

I understand and agree that information regarding my claim may be shared with other parties for fraud prevention purposes, and that I consent to my claim being investigated as part of this process.

DATA PROTECTION ACT 1998 - I hereby consent to any information about me being processed for the purposes of providing insurance and claims handling, which may necessitate the provision of such information to third parties.

Signed

Please print name

Date