

30 Mather Avenue
Liverpool
L18 5HT

Tel: 0151 724 1930
Fax: 0151 724 1971

Email: info@unitymutual.co.uk
Website: www.unitymutual.co.uk

Dear Member,

This document contains a claim form for completion.

The form is in three parts and notes for your guidance are given below. It is very important that all relevant parts and questions are fully completed as your claim cannot be assessed with incomplete information.

CLAIMANT'S STATEMENT - All Claimants should complete questions 1 - 12 inclusive and sign the declaration.

CONSENT TO OBTAIN A MEDICAL REPORT - Please read and understand your rights, then sign the Claimant's Consent indicating whether or not you wish to see any report requested.

DOCTOR'S STATEMENT - This need only be completed by your Medical Practitioner if you are not enclosing an original (not photocopied):

- Doctor's Statement (Form Med 3)
- or Hospital Certificate (Form Med 10)
- or DFWP Certificate (Form BF30)/Certificate for voluntary sickness insurance

Should you receive a 'may be fit for work' certificate we shall require supporting documentation from your employer outlining the agreed temporary arrangements.

If you wish the Medical Certificate to be returned to you or forwarded, please enclose a stamped addressed envelope.

Please note that any fee payable for a Medical Certificate is at the expense of the Member and not the Society.

Please use this letter as a "checklist" when returning your forms. If you have any questions regarding your claim, please contact the Claims Department during normal office hours. Under present office procedures sickness benefit is issued on a monthly basis.

Yours sincerely

Claims Department

30 Mather Avenue, Liverpool L18 5HT Tel: 0151 724 1930 Fax: 0151 724 1971
Email: info@unitymutual.co.uk Website: www.unitymutual.co.uk

CLAIMANT'S STATEMENT

1. Surname Title
Forenames

2. Membership No.

3. Home Address
Postcode Tel No.
Email Address

4. Occupation (if this is not teaching, please describe your duties)
If retired, please state date of retirement and whether normal, early or for medical reasons

5. Name and address of employer

6. Name and address of General Practitioner

7. On what date were you first medically certified unfit for your occupational duties?

8. What is the exact nature of your incapacity?

9. Have you engaged in any work since your incapacity began?
Yes No
If yes, please give details

10. Are you entitled to any other disability benefits from any other insurer?
Yes No
If yes, please give the Company, address and policy number(s)

11. Please give the date you returned, or expect to return to your occupation:

12. Has your incapacity ended and is this your full claim?
Yes No

DECLARATION - To be signed by the Claimant

I declare that the information given in the Claimant's Statement is true and complete to the best of my knowledge and belief. I authorise my employer to provide all necessary information as required by the Society.
Data Protection: The information you provide within this form is used to process your sick pay claim and administrate your Sickness Income Plan.

We will never share your data with any third party without your consent. We may, however, wish to contact you in the future with marketing material that we believe may be of interest to you. However, we will only do this if you are happy to receive such information. If you're happy to receive marketing information from us, please let us know how you prefer to be contacted. You can tick as many of the boxes below as you wish. If you do not wish to be added to our marketing list, simply leave the tick boxes empty.

Post Email Telephone (home) Telephone (mobile – including SMS/MMS). Your marketing preferences will remain in place until you let us know otherwise. You can update us at any time, opting in or out of marketing, or change the ways in which you would prefer us to contact you. You can update your marketing preferences by contacting us directly. You can find further information at <https://www.unitymutual.co.uk/privacy/>

Signature Date

CLAIMANT'S STATEMENT

CLAIMANT'S RIGHTS - To be read by the Claimant

Please read the information given below which explains your rights under the Access to Medical Reports Act 1988 and sign the Consent to obtain a Medical Report. Under the rules of the Society, we may require you to be medically examined (at our expense) or seek medical information from your own or from any other doctor who has attended you. Signing the Consent now will save time later and we want to be able to deal with your claim as quickly as possible.

You do not have to give your consent to our Medical Adviser being provided with medical information but if you do, you have the right to tell the doctor that you wish to see the report before it is sent to us. If you express a wish to see the report, the doctor cannot send it to us unless either he has shown it to you or 21 days have passed without you having contacted your doctor about arrangements for you to see it.

Of course, the quicker you act, the quicker your claim can be considered and we will not be able to proceed with your claim in the absence of medical information.

Whether or not you say you wish to see the report before it is sent to us, the doctor must let you see a copy of it for up to six months after it is supplied, upon request. If you do ask the doctor for a copy of the report, you can be charged a reasonable fee to cover costs.

Once you have seen a report before it is sent to us, the doctor cannot submit it until you give your consent. You can write to your doctor asking to amend any part of the report which you consider to be incorrect or misleading. You may also have attached to the report, a statement of your views on any part where you and the doctor are not in agreement and which the doctor is not prepared to alter.

The doctor is not obliged to let you see any part of the report if, in his opinion, that would be likely to cause serious harm to your physical or mental health or that of others; or would indicate the doctor's intentions towards you; or if disclosure would be likely to reveal information about - or the identity of - another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional involved in caring for you. In such cases, the doctor must notify you and you will be limited to seeing any remaining part of the report. If it is the whole report which is affected, he must not send it to us unless you give your consent.

DOCTOR'S NOTES - To be read by the Doctor completing this report

Under the Access to Medical Reports Act 1988, certain legal requirements have to be complied with by both insurers and any doctor who has responsibility for the health care of any individual making a claim.

The Claimant must have given consent for us to approach you and this consent is below. This consent indicates whether the Claimant wishes to see the report before it is sent to us. If the Claimant has said that they do not wish to see the report, there is no need to delay. Please send the report to the address given at the end of this form.

If the Claimant has elected to see the report, he/she has been told that he/she has 21 days to make an appointment with you to see the report.

You have the right to withhold the report or part of it from the Claimant if you consider it might be harmful and, if in doubt, you may wish to take advice from your Medical Protection Society or Defence Union on this matter.

If, after 21 days, they have not approached you, you should send the report to the address given at the end of this form.

Please keep a copy of this report for your records as the Claimant has the right during the next six months to see it, for which you may make a reasonable charge.

CLAIMANT'S CONSENT - To be signed by the Claimant

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, and in connection with my Insurance claim, hereby consent to Unity Mutual being provided with medical information 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 that consent shall have the validity of the original.

I wish to see the report before it is sent to Unity Mutual

I do not wish to see the report before it is sent to Unity Mutual

Signature

Date

