BERKSHIRE HATHAWAY SPECIALTY INSURANCE

Group Personal Accident & Business Travel Insurance

PERSONAL ACCIDENT CLAIM FORM

Please complete and return the signed claim form to: claimsnoticeeurope@bhspecialty.com
Alternatively, it can be sent to: BHSI Claims, 4th Floor, 8 Fenchurch Place, London, EC3M 4AJ
For further information, please visit our website: https://www.bhspecialty.com/claims/claims-UK/

POLICY DETAILS

Policy Number: _____

Policyholder: _____

Policyholder Address:

_____

INSURED PERSON

Full Name: _____

Address:

_____

Date of Birth (DD/MM/YYYY): _____

Occupation and/or relationship to the Policyholder (e.g. Director, Employee, Partner/Child of a Director/Employee, Visitor, Other. If Other, please specify):

_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed

Phone Number: _____

Email Address: _____

YOUR DETAILS *(if you are not the Insured Person)*

Full Name: _____

Address:

_____

Date of Birth (DD/MM/YYYY): _____

Relationship to the Insured Person (e.g. Broker, HR, Finance, Partner/Child of a Director/Employee, Other. If Other, please specify):

_____

Phone Number: _____

Email Address: _____

ACCIDENT DETAILS

Date (DD/MM/YYYY): _____ Time (HH:MM): _____

Location:

_____

Description of the Accident:

Applicable Coverage Section:

- ☐ Accidental Death
- ☐ Permanent Partial Disablement (PPD)
- ☐ Permanent Total Disablement (PTD)
- ☐ Temporary Total Disablement or Temporary Disablement (TTD/TPD)

Please complete the corresponding Coverage Section below:

Coverage Section: Accidental Death
Please include a copy of the Death Certificate.

Coverage Section: Permanent Partial Disablement (PPD)
Please include a completed copy of the Medical Certificate.

Coverage Section: Permanent Total Disablement (PTD)
Please include a completed copy of the Medical Certificate.

Coverage Section: Temporary Total Disablement (TTD) or Temporary Partial Disablement (TPD)

Date the Insured Person stopped work (DD/MM/YYYY): _____

Date the Insured Person returned to work or expect to return (DD/MM/YYYY): _____

Number of weeks out of work: _____

Have you/has the Insured Person suffered from the same or similar injuries previously? ☐ Yes ☐ No

If yes, details of previous injury:

Was a claim made? ☐ Yes ☐ No

If yes, details of previous claim:

Please include a completed copy of the Medical Certificate.

MEDICAL TREATMENT

Have you/has the Insured Person received medical treatment? ☐ Yes ☐ No
If yes, details of medical treatment:

If yes, medical facility:

DATA PRIVACY NOTICE

BHSI is committed to protecting your personal data. Please consult our Privacy Notice which will explain how we use the information we collect about you and how you can exercise your data protection rights. Our Privacy Notice is available at https://www.bhei.eu/privacy-policy/.

Please note that where you provide us with details about other people, you represent to have the authority and any necessary consent to provide such information to us.

ACCESS TO MEDICAL REPORTS

Access to Medical Reports Act (1988), Access to Medical Records Act (1988)/Access to Personal Files and Medical Reports (Northern Ireland) Order 1991/Access to Health Records and Reports Act 1993 (Isle of Man), Data Protection Act (1988) ("The Acts").

We require completion of a medical report by the doctor who is caring for you, to enable us to deal with an insurance claim. We need your consent to the supply of this report by signing in the space indicated below. Before doing so, however, you should read this note carefully, as it sets out your rights under the Acts and the procedures for dealing with reports. You do not have to give your consent to our being provided with a report but if you do, you have the right to tell the doctor you wish to see the report before it is sent to us, in which case 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 arrangement for you to see it. Of course, the quicker you act, the quicker the claim can be considered, and we may not be able to proceed with the 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 for up to six months after it is supplied, if you ask. If you ask the doctor for a copy of the report, he can charge you a reasonable fee to cover his costs. Once you have seen the report, before it is sent to us the doctor cannot submit it until he has your consent. You can write to the doctor asking him to amend any part of the report which you consider to be incorrect or misleading and 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 a report if, in his opinion, it would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the doctor's intention 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.

CONSENT TO OBTAIN A MEDICAL REPORT

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, and, in connection with an insurance claim, hereby consent to BHSI 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 this consent shall have the validity of the original.

☐ I do not wish to see the report before it is sent to BHSI

☐ I do wish to see the report before it is sent to BHSI

DECLARATION

I declare that the statements on this form and the information provided in addition are true and complete to the best of my knowledge and belief. I understand that a false declaration may invalidate my claim.

I confirm that the undersigned is authorised to act for and on behalf of all persons included in this claim, who seek indemnity and/or compensation.

I understand that the information I provide will be used and shared in the ways described in the Privacy Notice.

SIGNED

Signature: _____

Full Name: _____

Date(DD/MM/YYYY): _____

Berkshire Hathaway European Insurance DAC (BHEI DAC)
Private Company Limited by shares. Registered Office: 2nd Floor, 7 Grand Canal Street Lower, Dublin 2, D02 KW81, Ireland
Registered in Ireland; Company Registration Number: 636883; VAT No. 3583603
BHEI DAC is regulated by the Central Bank of Ireland.

BHEI has a branch in the United Kingdom.
Registered office: 4th Floor, 8 Fenchurch Place, London EC3M 4AJ
Company Registration Number: FC037742
FCA reference number: 835812
BHEI DAC UK branch is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and Prudential Regulation Authority.