BERKSHIRE HATHAWAY SPECIALTY INSURANCE

Group Personal Accident & Business Travel Insurance

MEDICAL CERTIFICATE

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/

This form is to be completed by any medical professional, doctor, consultant, or specialist, licensed to practice medicine and who is currently registered with the General Medical Council in the United Kingdom (or registered with an overseas equivalent) and holds a recognised, professional qualification in a relevant field of medicine to the bodily injury or illness sustained by the Insured Person. This does not include:

1. an Insured Person, or
2. an Insured Person's Partner, or
3. a member of an Insured Person's family, or
4. a Director or Employee of the Insured.

POLICY DETAILS

Policy Number: _____

Policyholder: _____

Policyholder Address:

_____

INSURED PERSON

Full Name: _____

Address:

_____

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

Are you the Insured Persons usual Medical Professional? ☐ Yes ☐ No

MEDICAL TREATMENT SUMMARY

Cause of Medical Treatment: ☐ Accident ☐ Sickness

Please complete the corresponding Cause of Medical Treatment sections below.

Was the Insured Person hospitalised? ☐ Yes ☐ No

If yes, Medical Facility:

_____

Were BHSI Assistance contacted? ☐ Yes ☐ No

If yes, BHSI Assistance reference number: _____

CAUSE OF MEDICAL TREATMENT: ACCIDENT

Description of Accident:

Date of Accident (DD/MM/YYYY) _____

Time of Accident (HH:MM): _____

Location of Accident:

Please select the extent of the bodily injury using the options below:

☐	1	Death
	2	Permanent Partial Disablement
☐		i) Loss of Limb(s)
☐		ii) Loss of Sight – in one or both eyes
☐		iii) Loss of Speech
		iv) Loss of Hearing
☐		(i) in both ears
☐		(ii) in one ear
		Total loss of use of:
☐		v) The back or spine below the neck with no damage to the spinal cord
☐		vii) The neck or cervical spine with no damage to the spinal cord
☐		viii) A shoulder, elbow, wrist, hip, knee, or ankle
☐		ix) Removal by surgical operation of the lower jaw
		Loss of or total loss of use of:
☐		x) A thumb
☐		xi) A forefinger
☐		xii) A big toe
☐		xiii) Any other finger or any other toe

☐	3	Permanent Total Disablement *Definition – "A permanent, total, and irrecoverable disablement which has lasted for at least 12 months and totally prevents an Insured Person from performing their duties of employment as described in their contract of employment with You, and which in all probability, will continue for the remainder of their life, as determined by a Medical Professional."* *Please also confirm whether Permanent Total Disablement is only from usual occupation or if it is from any occupation:* ☐ Usual occupation ☐ Any occupation
☐	4	Temporary Total Disablement *Definition – "Total disablement which temporarily prevents an Insured Person from performing any of their Usual Occupation."*
☐	5	Temporary Partial Disablement *Definition – "Partial disablement which temporarily prevents an Insured Person from performing at least 50% of their Usual Occupation."*
☐		Other. Please give details of any other injuries:

CAUSE OF MEDICAL TREATMENT: SICKNESS

Description of Sickness:

Date the symptoms first appeared (DD/MM/YYYY): _____

Time the symptoms first appeared (HH:MM): _____

Location of Sickness:

Diagnosis:

Treatment and prognosis:

Has the Insured Person suffered from this Sickness before? ☐ Yes ☐ No

If yes, when? (DD/MM/YYYY): _____

GENERAL HEALTH

Could the Insured Persons Medical history have contributed to the Accident/Sickness? ☐ Yes ☐ No
If yes, please provide details:

Could the Insured Persons Medical history impact their recovery? ☐ Yes ☐ No
If yes, please provide details:

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.

SIGNED

Signature: _____

Full Name: _____

Date(DD/MM/YYYY): _____

Qualifications: _____

Medical Facility Address:

_____

Medical Facility Stamp:

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.