British Friendly Claim Form

Century British Airways Benefit Fund (BABF) Scheme A + B

BRITISH FRIENDLY
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IMPORTANT NOTE

Answer all questions fully in BLOCK CAPITALS, tick all relevant boxes and return this form within 7 days of receipt. Please note, providing a false statement may lead to your policy being cancelled and your entitlement to all benefits and premiums paid forfeited. The Society reserves the right to refer fraudulent claims to the relevant law enforcement authorities.

- In order to process your claim, the Society may require additional medical evidence and you may be required to undergo a medical examination.
- In order to receive benefit you must be sick continuously for 8 days.
- You must supply a Doctor's certificate in order for your claim to be processed.
- Payments are made on a Thursday on a fortnightly basis for the duration of your claim and will be available in your account within 3 working days after the payment is made.
- Your claim will be paid by direct credit to your account as detailed in this form and must be your own or a joint named account. Payments cannot be made to a third party account.

1. YOUR DETAILS

Firstname		Policy number	
Surname		Telephone (home)	
Date of birth		Telephone (work)	
Address		Mobile	
		E-mail	
Postcode			

2. YOUR EMPLOYMENT DETAILS

Your current job			
Supervisor/Manager name		Supervisor/Manager telephone	
Workplace/Unit address			
Postcode			

3. YOUR BANK DETAILS (PAYMENTS CANNOT BE MADE TO THIRD PARTIES)

Account holder name		Account number	
Bank/building society name		Brand sort code	
Bank/building society address			
Postcode			

4. YOUR CLAIM DETAILS (SCHEME A)

Please select your level of benefit (if known). Level 1 ☐ Level 2 ☐

Please provide details of your illness or injury.

What date did your illness or injury start? DD/MM/YYYY

Have you done any work since your illness or injury started? Yes ☐ No ☐

If yes, please provide details of the work you've done.

Which duties of your job are you unable to perform?

What date did you become continually absent from work? DD/MM/YYYY

Is your illness or injury the result of an accident? Yes ☐ No ☐

If yes, please provide full details (ie. road traffic accident, participation in a sport or hobby).

Have you suffered from this or any related conditions before? Yes ☐ No ☐

If yes, please provide dates and full details of when this condition last occurred.

Is your illness or injury related to any of the conditions below? (Please tick all that apply)

Pregnancy ☐ Child birth ☐ Miscarriage ☐ Drug abuse ☐ HIV ☐

Alcohol abuse ☐ Cosmetic surgery ☐ Assisted conception ☐ Voluntary sterilisation ☐

When did you first seek medical advice? DD/MM/YYYY

Who did you first seek medical advice from?

Please provide full details of all doctors, specialists, hospitals or other medical professionals you've consulted about your current illness or injury and details of any planned treatment, investigations or tests.

ATTACH/ENCLOSE COPIES OF ANY REPORTS YOU HAVE REGARDING YOUR CONDITION.

Are you currently in hospital? Yes ☐ No ☐

If yes, please state dates for the following:

Hospital admission date DD/MM/YYYY

Expected discharge date DD/MM/YYYY

Have you recovered from your current illness or injury? Yes ☐ No ☐

If yes, what date was your recovery complete? DD/MM/YYYY

If no, when is your expected recovery date? DD/MM/YYYY

5. YOUR DOCTORS DETAILS

Name | Telephone

Address

Postcode

6. YOUR MEDICAL BENEFIT DETAILS (SCHEME B)

Please select your level of benefit (if known). Level 1 ☐ Level 2 ☐ Level 3 ☐

Please complete the relevant section(s) below:

Section A - Hospital In-Patient Benefit (subject to maximum per year)

Hospital admission date DD/MM/YYYY

Have you been discharged from hospital? Yes ☐ No ☐

If yes, what was the discharge date? DD/MM/YYYY

If no, what date do you expect to be discharged? DD/MM/YYYY

PLEASE ATTACH/ENCLOSE A HOSPITAL CERTIFICATE OF ADMISSION/DISCHARGE

Section B - Dental Benefit (subject to maximum per year)

50% of the total cost of treatment £

PLEASE ATTACH/ENCLOSE THE RECEIPT IN SUPPORT OF YOUR DENTAL CLAIM

Section C - Optical Benefit (subject to maximum per year)

50% of the total cost of treatment/prescription £

PLEASE ATTACH/ENCLOSE THE RECEIPT IN SUPPORT OF YOUR OPTICAL CLAIM

7. OTHER BENEFIT ENTITLEMENTS

If your illness or injury is a result of an accident or a work-related incident, are you or do you intend to seek compensation or start legal proceedings from any third party as a result of your illness or injury? Yes ☐ No ☐

If yes, please provide full details including the name and address of any solicitors acting on your behalf.

8. YOUR DISCRETIONARY MUTUAL BENEFITS

Have you signed up to Mutual Benefits? Yes ☐ No ☐

Are you aware that through Mutual Benefits you have access to healthcare services provided by Square Health at no extra cost including virtual GP consultations, physiotherapy, counselling and a 2nd opinion service? Yes ☐ No ☐

Do you want help signing up to Mutual Benefits or accessing the Square Health services in support of your claim? Yes ☐ No ☐

For more information about Mutual Benefits or to sign up visit members.britishfriendly.com, call 01234 358 344 option 4 or e-mail mutualbenefits@britishfriendly.com.

9. YOUR RIGHTS IN OBTAINING A MEDICAL RECORD

Before we can apply for a medical report from your doctor we need your consent, and a declaration for this is detailed in the section below. However, you should know that you have certain rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. This consent will remain valid for two years from the time you date your first signature.

The main points of the Act are as follows:

- If you indicate that you do not wish to see the report we will notify you if we apply for one. However, if before such a report is sent to us you write to your doctor requesting to see it, you will have 21 days to contact your doctor about arrangements for you to see the report.
- If you indicate that you wish to see the report, we will write to you at the same time as we contact your doctor. We will indicate that you have asked to see the report and that you have 21 days to contact your doctor to make arrangements to do so. When you have seen the report the doctor may not send it to us until you have given your consent to do so. If you do not contact your doctor within 21 days the report will be sent to us.
- You can ask your doctor if he/she will amend any part of the report which you consider to be misleading. If your doctor is not in agreement you may attach your comments.
- During the six months after we have received your report you may ask your doctor to see a copy. Should you ask for a personal copy of the report the doctor can charge you a reasonable fee to cover the cost.
- In some circumstances the doctor may decide, in the interest of your health, or to respect the interest of other persons, that you should not see all or part of the report. The doctor will notify you of this and you will have the right to see any remaining part of the report. If it is the whole of the report which is affected, this will not be given to us without your consent.
- You can withhold your consent (in which case we may be unable to proceed with your claim).

10. DECLARATION, AUTHORITY AND CONSENT

- I have been informed of, and understand, my statutory rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. In connection with the claim submitted, I hereby consent to British Friendly seeking medical information from any doctor who, at any time, has attended me concerning anything which affects my physical and/or mental health and that this information (including full medical records or notes where requested) will be passed to British Friendly. I agree that a copy of this consent shall have the validity of the original.
- I will notify British Friendly immediately if my circumstances relevant to this claim alter in any way or if I should carry out any work whether paid or unpaid.
- I declare that to the best of my knowledge and belief the information given on this form is true and complete and that I am the person referred to in the particulars given. I understand that if, at any time, I am found to have made a false statement, I am liable to expulsion under the terms of the Society's rules.

Please tick the boxes if you give consent for each of the following:

☐ I have read the Society's Main Privacy Policy and the Society's Privacy Policy for Claimants accessible at **https://members.britishfriendly.com/privacy-policy/** and have understood how my personal information will be used by the Society.

☐ I consent to the Society (and its external partners) processing my 'special category' information (which includes medical and genetic information) in accordance with the Society's Privacy Policies.

☐ I understand that this processing is necessary for the Society to offer me this policy or to process my claim and that if I refuse my consent or later withdraw my consent, my policy will have to be cancelled.

☐ I wish to see my medical report before it is sent to British Friendly.

Please sign to confirm you have read and understood the Declaration, Authority and Consent.

Print your name		**Your date of birth**	DD/MM/YYYY
Your signature		**Date**	DD/MM/YYYY

Please tick the box to confirm that you have attached/enclosed the document in support of your claim:

☐ Doctor's Certificate

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Version: 10.4.18