BRITISH FRIENDLY

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# CLAIM FORM

British Airways Benefit Fund (BABF) Sickness Benefit Plus

**IMPORTANT NOTES: Please read carefully**

- Please answer all questions fully in block capitals and tick all relevant boxes.
- To confirm that your earnings support the level of cover you have please enclose a copy of your last pre-disability payslip.
- Doctor's certificates are required from the eighth day of an illness.
- The Society reserves the right to obtain additional medical evidence including a medical examination, or make further enquiries as necessary.
- Payments will normally be made on a Thursday, on a fortnightly basis for the duration of this claim. This will be by direct credit to your account as detailed below and must be your own or a joint named account. Payments cannot be made to a third party account.
- Payment should be in the specified bank/building society account within 3 working days after payment is made.
- Please take reasonable care to complete this form as 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.

1. Membership number: _____
2. Staff number: _____
3. Date of birth: _____
4. Full name: _____
5. Address: _____

   _____

   _____ Postcode _____
6. Home telephone number: _____
7. Work telephone number: _____
8. Mobile number: _____
9. Email address: _____

**PLEASE PROVIDE YOUR BANK/BUILDING SOCIETY DETAILS - PAYMENTS CANNOT BE MADE TO THIRD PARTY ACCOUNTS**

10. Bank/Building Society account number: | | | | | | | | |
11. Branch sort code: | | | | | | |
12. Name(s) of Account Holder(s): _____
13. Name of Bank/Building Society: _____
14. Address of Bank/Building Society: _____

    _____

    _____ Postcode _____

15. Please state your current occupation: _____

16. Name of Supervisor/Manager: _____

17. Supervisor/Manager contact number: _____

18. Workplace/Unit Address: _____

_____

Postcode

19. Please state the Plan you belong to (please tick): Sickness Benefit: ☐ Sickness Benefit Plus: ☐

20. Please state the level of cover (please tick):

Level 1: ☐ Level 3: ☐ Level 5: ☐

Level 2: ☐ Level 4: ☐ Level 6: ☐

21. Please provide full details of your illness or injury: _____

22. Have you previously suffered from this or any other related condition? If so, please give full details to include dates: _____

23. On what date did you become unwell? _____

24. On what date did you become continually absent from work? _____

25. Please give details of any work that you have done since that day? _____

26. When did you first seek medical advice and from whom? _____

27. Please provide full details of all doctors, specialists, hospitals or other medical professionals you have consulted about your incapacity including details of current or planned treatments, investigations or tests.

    **Please send copies of any specialist reports you have regarding your condition.**

28. If you are currently a hospital in-patient, please state the dates of your admission and expected discharge:

29. If you have now recovered from your illness or injury, when was your recovery complete?

30. If you have not recovered, when do you expect your recovery to be complete?

31. Does your illness or injury arise from, or are you currently being treated for, any of the following conditions.

    Please tick and give full details in the space provided and continue on a separate sheet if necessary:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Pregnancy | ☐ | ☐ | Alcohol abuse | ☐ | ☐ |
| Child birth | ☐ | ☐ | Drug abuse | ☐ | ☐ |
| Assisted conception | ☐ | ☐ | HIV | ☐ | ☐ |
| Miscarriage | ☐ | ☐ | Cosmetic surgery | ☐ | ☐ |
| Voluntary sterilisation | ☐ | ☐ | | | |

32. If your illness or injury is the result of an accident, please provide full details of how this occurred. For example, a fall, road traffic accident, participation in a sport, leisure / hobby activity, charity event, etc. Please continue on a separate piece of paper if necessary.

33. If your illness or injury is a result of an accident or work-related incident, is a claim being made against any third party? Yes ☐ No ☐

If Yes, please give full details.

**PLEASE SIGN AND READ THE DECLARATION, AUTHORITY AND CONSENT ON THE NEXT PAGE**

## Consent to obtain a Medical Report

- Before we can apply for a medical report from your doctor we need your consent, and a declaration for this appears overleaf. 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 of your first signature.

The main points of the Act are as follows:

a. 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 then have 21 days to contact your doctor about arrangements for you to see the report.

b. 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.

c. 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.

d. 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 costs.

e. 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.

f. You can withhold your consent (in which case we may be unable to proceed with your claim).

## Declaration, Authority and Consent

TO BE SIGNED BY ALL CLAIMANTS

- On a continuing basis, I authorise the release of any information to British Airways Benefit Fund, which is part of the British Friendly (and to any third parties acting on its behalf) which it considers relevant to this claim. This may include information requested from my employer (including personnel and occupational health records), Department of Work and Pensions, other insurance companies or any other relevant source.
- I will notify British Airways Benefit Fund 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.
- I agree to British Airways Benefit Fund using such methods as they consider necessary and reasonable in order for the validity of this claim to be established.
- I consent to the recording of any telephone calls made to or from British Airways Benefit Fund, which is part of the British Friendly (or third parties acting on its behalf).
- I consent to the computer and other processing and use of personal and medical details supplied in support of this claim by the data controllers and relevant third parties for the purposes of claims assessment and validation, fraud prevention, policy administration and reinsurance.
- 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 Airways Benefit Fund 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 Airways Benefit Fund. I agree that a copy of this consent shall have the validity of the original.

Please tick the box below if you wish to see the report before it is returned to us:

☐ I wish to see the report before it is sent to the Insurer

Print Name: _____

Date of birth: _____

Doctor's name: _____

Doctor's address: _____

_____

_____ Postcode

Doctor's telephone number: _____

Signature: _____ Date: _____

THIS FORM MUST BE RETURNED WITHIN 7 DAYS OF RECEIPT

**British Friendly Society Limited**
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