

Claim form

MetLife Claims
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Sunderland
SR5 9RB

0800 917 1333
www.metlife.co.uk
claims@metlife.uk.com

In order to make a claim under your policy, please complete this form in full. Should you have any queries completing the form, please contact your claims team on the telephone number above and use the checklist below to ensure all information is provided.

You are under a duty to provide true, accurate, and complete information in this claim form and when providing information to MetLife in order for us to assess your claim. If you provide misleading information it may result in your claim being rejected. If the requirements under our claims procedures are not complied with we may not pay your claim. Please refer to the Policy Terms and Conditions for claims that are excluded from cover.

Before submitting your claim form, please ensure you have:

- Signed the declaration and consent
- Filled out your bank details (if the claim is not being paid into the account we collect premiums from)
- Filled out your section of your claim form
- Asked a Doctor to fill out the Medical Statement
- Provided a copy of the hospital discharge summary (if relevant)
- Provided proof of your main occupation (in the case of sports-related injuries – please see notes on page 6)

Policyholder name:

Policy number:

BPA number:

Section 1 - Declaration and consent

Access to medical reports

It may be necessary for us to ask any Doctor who has attended to you to provide us with a medical report, but before we can do this, we need your consent. Before signing the declaration below, you should know that you have certain rights under the Access to Medical Reports Act 1988 and or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. You do not have to give your consent, but if you do not, we may be unable to proceed with processing your claim.

You can say whether you wish to see the report before it is sent to us. We will then tell you if we request a report from your Doctor. We will also inform your Doctor that you wish to see the report before it is sent to us. You will then have 21 days to contact your Doctor to arrange to see this report. If you choose not to see the report before it is sent, you can ask your Doctor for a copy within 6 months of it being supplied to us.

If you consider any part of the report to be misleading, you can ask your Doctor to amend it. If your Doctor refuses, you may add your own written comments. Your Doctor does not have to let you see any part of the report if, in their opinion, you or others would be harmed by it, or if the report contains information about another person, unless that person consents to you seeing the report. You will be informed if any part of the report is redacted in this way.

Please note that if you do wish to see any report before it is sent to us then this may cause the processing of your claim to take longer than would otherwise be the case.

Data protection

MetLife is a data controller in respect of any personal data you provide to us. The ways in which MetLife may collect, share or process your personal data are explained in MetLife's Privacy Notice. MetLife's Privacy Notice also explains your rights regarding your personal data. A copy of MetLife's Privacy Notice is available on our website, www.metlife.co.uk.

Should you have any questions or concerns, please contact the MetLife Data Protection Officer at DataProtectionUK@MetLife.com.

Policyholder name:

Policy number:

BPA number:

Declaration and consent

By signing below, I confirm that I have read and I understand the explanation above of my rights under the Access to Medical Reports Act 1988 and or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. I consent to MetLife applying to my treating Doctors or medical practitioners to obtain medical reports and my medical notes and records.

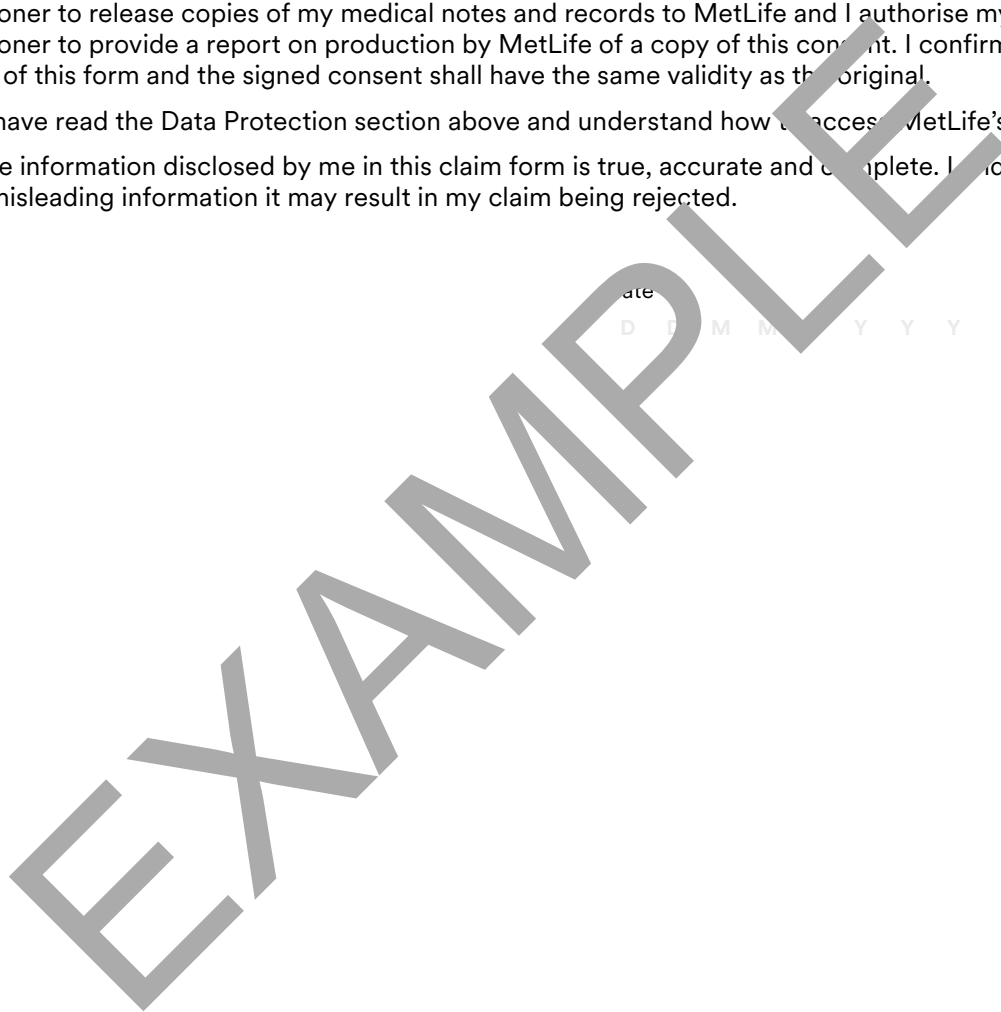
I do want to see any medical report before it is sent to MetLife I do not want to see any medical report before it is sent to MetLife

I consent to MetLife requesting information from any Doctor or medical practitioner who has treated me in respect of any medical condition affecting my physical or mental health. I authorise my treating Doctor and my treating medical practitioner to release copies of my medical notes and records to MetLife and I authorise my Doctor or medical practitioner to provide a report on production by MetLife of a copy of this consent. I confirm that a copy or electronic copy of this form and the signed consent shall have the same validity as the original.

I confirm that I have read the Data Protection section above and understand how to access MetLife's Privacy Notice. I declare that the information disclosed by me in this claim form is true, accurate and complete. I understand that if I have provided misleading information it may result in my claim being rejected.

Name of claimant

Please sign here



Policyholder name:

Policy number:

BPA number:

Section 2 - Bank account details (only complete this section if relevant)

Following our assessment of your claim, if both the policy and the bank account we collect premiums from are in your name, we will automatically pay benefit into that bank account and you don't need to do anything further. Payment should clear within 3 working days of MetLife confirming payment has been made.

If we collect premiums from a bank account that is not in your name, and you would like us to pay benefit into your bank account, please provide details of your bank account below.

Name of Bank/Building society

Account holder name

Bank account number

Sort code - -

If you are requesting for payment to be made to a bank account that is not in your name, please provide details below of where you would like payment to be made.

We will only make payment to a bank account that is not yours in limited circumstances, for example, if you do not hold a UK bank account. It will be at our absolute discretion whether we agree to pay to a bank account that is not yours.

Name of Bank/Building society

Account holder name

Bank account number

Sort code - -

Reason for payment to this bank account

Relationship to the bank account holder

Please be advised that if you have completed any of the sections above, we will require proof of identification. Please provide a copy of a Passport/Driving Licence/National ID card/UK Forces ID card, in addition to a copy of a bank statement/image of the front of the Debit card confirming the sort code and account number of the account holder.

We will still require this information even if you are providing us with account details in your own name.

These documents are required for anti-money laundering purposes and to verify the bank account to which we make payment.

If you request we make payment to a bank account that is not yours we will require proof of identification (Driving License, Passport or National Identity card) from the bank account holder.

Policyholder name:

Policy number:

BPA number:

Section 3 - Details of Claim

Please only complete your address here if you have moved since taking out your policy and we don't have your new address.

Address

Town/City

Postcode

Email

Please provide us with your email address if you are happy for us to contact and update you on the progress of your claim via email.

Mobile number

Home telephone number

General Practitioner (GP)

Title

Dr Other - please specify

First name(s)

Surname

Address

City

Country

Postcode

Telephone number

Email address (if known)

Name(s) of any other treating medical professional (for your injury or illness you are claiming for)

Title

Dr Other - please specify

First name(s)

Surname

Address

City

Country

Postcode

Telephone number

Email address (if known)

Please confirm who you have asked to complete the medical statement

Policyholder name:

Policy number:

BPA number:

Accident Claims

If you are claiming for an accidental injury please complete this section.

If you are only claiming for UK hospitalisation due to sickness, please move to page 7 and complete that section.

Date of accident

Time of accident

Please tell us what happened

Where did this accident happen?

What injuries are you claiming for?

If you were provided with a hospital letter or copy of your X-ray or MRI scan please send this to us.

If the accident occurred whilst playing sport, please confirm:

Type of sport

Team name

Important

Do you get paid to play this sport? Yes No

If you get paid to play this sport please can you provide a copy of a payslip from your main occupation so that we can confirm you are not a professional sports person.

Policyholder name:

Policy number:

BPA number:

For accidents reported to the police

Has the accident been reported to the police? Yes No

Please note, if the accident is still under investigation with the police, we may have to wait for the outcome of the investigation before we can make a decision.

If the accident was reported to the police, please state the address of the police station, and any crime reference number you may have been given:

Name of police station

Address

City

Country

Postcode

Name of police officer (if known)

Telephone number (if known)

Crime reference number

Please send us copies of any correspondence you have from the police

UK Hospitalisation claims – accident and sickness

Please complete this table if you have been admitted to a UK hospital for more than 24 hours

	MUST BE PROVIDED		MUST BE PROVIDED			
Admission date	Admission time	Discharge date	Discharge time	Hospital name and town	Ward name	

Please enclose copies of your discharge form or your hospital letters

Why were you admitted to hospital?

Policyholder name:

Policy number:

BPA number:

To be completed by you:

Full name

Injuries or medical condition claiming for

Section 4 - Medical Statement - to be completed by the Doctor

Full name of the patient

Date of birth

D D M M Y Y Y Y

Diagnosis (include details of any changes to diagnosis)

Date of first consultation

Last consultation

Total number of consultations

D D M M Y Y Y Y

D D M M Y Y Y Y

Date symptoms first appeared

Date diagnosed

D D M M Y Y Y Y

D D M M Y Y Y Y

Who made the diagnosis?

How was the diagnosis made?

If the diagnosis was made via clinical examination rather than a diagnostic tool such as a test, X-ray, scan, what symptoms supported the diagnosis?

What treatment has your patient received? If surgery has taken place/is planned please include details of the surgery.

If this was an accidental injury please advise how the accident happened and all the injuries sustained.

Policyholder name:

Policy number:

BPA number:

Has the patient been admitted to hospital for 24 hours or more in relation to this illness or injury? Yes No

If 'Yes' please provide details

	MUST BE PROVIDED		MUST BE PROVIDED		
Admission date	Admission time	Discharge date	Discharge time	Hospital name and town	Ward name

Has the patient been referred to any other Doctor or specialist for treatment or advice in relation to the condition they are claiming for?

Yes No

If 'Yes' please provide details below:

Name

Address

City

Country

Postcode

Work telephone number

Email address (if known)

Name

Address

City

Country

Postcode

Work telephone number

Email address (if known)

Policyholder name:

Policy number:

BPA number:

Please provide details of any prior medical history for your patient that might relate to the current claim.

Please advise the type of break sustained (if more than one bone is broken please confirm details of each break).

Is the break (or each break if applicable) a complete break involving the entire width of the bone?

If the bone is bruised, please advise whether this is intraosseous or periosteal bruising.

If your patient has injured a ligament or tendon please confirm which ligament or tendon was injured, what grade of injury they have, and whether surgery was required for this?

Please use this space to provide any further information you feel is relevant or would assist us with your patient's claim.

EXAMPLE

Please return this form, as well as the following declaration and payment detail instruction, with copies of your patient's medical records and hospital letters related to this illness or injury.

Policyholder name:

Policy number:

BPA number:

Section 5 - Declaration - to be completed by the Doctor

I declare that I am the patient's GP / treating medical practitioner / specialist* and the information given in section 4 is true, accurate and complete. (*delete as appropriate).

With this form I am sending a copy of the requested medical reports. I declare that, in my opinion, there is nothing in the enclosed medical reports which would be likely to cause serious harm to the physical or mental health of the claimant or any other individuals, and any content which would be likely to cause such harm has been removed from the enclosed reports. I understand that if MetLife receives a subject access request from the claimant, it may be required to disclose the enclosed medical reports.

Print name

Date

D D M M Y Y Y Y

Please sign here

Address

City

Country

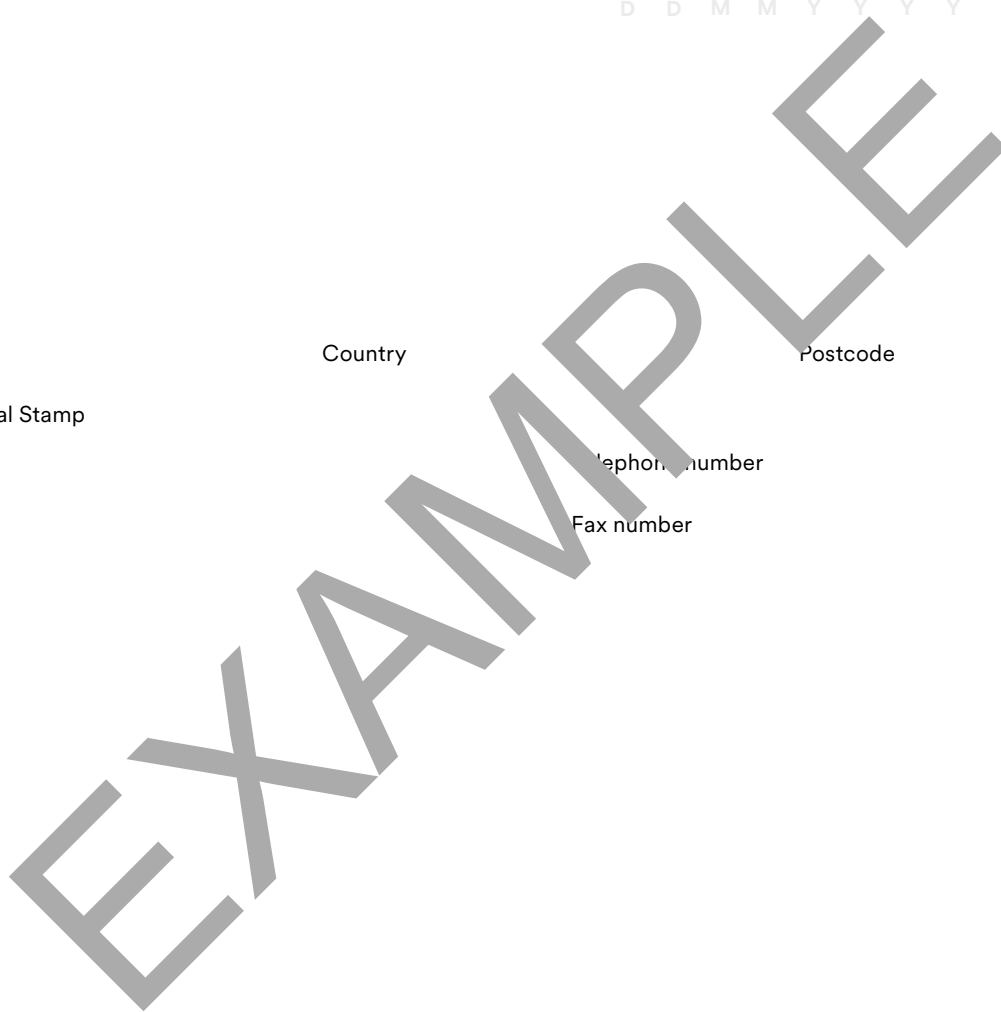
Postcode

Practice or Hospital Stamp

Telephone number

Fax number

Email address



Policyholder name:

Policy number:

BPA number:

Section 6 - Payment of fees for providing medical information - to be completed by the Doctor

We are processing an insurance claim for your patient. We appreciate that it may be appropriate for a reasonable professional fee to be charged associated with the provision of any relevant medical information in accordance with those agreed with the British Medical Association (BMA) relating to injury or illness claimed for.

In order for us to pay your fee, please either issue an invoice for this fee to MetLife (sending the information requested at the same time) or complete the details below and send us under separate cover the information requested.

If there are any questions around the provision of the information or payment of the medical fee please contact us on 0800 917 1333.

Payment instructions

Title

Dr Other - please specify

Name of Bank/Building society

Account holder name

Bank account number

Sort code

Fee charged for provision of medical information

Please note we only make payment by direct credit to ensure a quick and secure payment.

If the policyholder has paid this fee, please tick the box below and provide the policyholder with a receipt so we are able to reimburse them.

Fee paid by policyholder

Please return this form and all requested medical and supporting documentation to:

MetLife, Individual Claims, PO Box 1411, Sunderland, SR5 9RB

Policyholder name:

Policy number:

BPA number:

metlife.co.uk

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