

**CLAIMS ARE TO BE SUBMITTED WITHIN 90 DAYS OF A SPECIFIED
TERMINAL PROGNOSIS FIRST BEING DIAGNOSED**

Police Federation Statement

To be completed by the **Police Federation** in respect of the person for whom the benefit is being claimed, and returned to Scottish Police Federation, 5 Woodside Place, Glasgow, G3 7QF or your local SPF Office. The issue of this form is in no way an admission of liability.

A terminal illness is any advanced or rapidly progressing incurable illness where, in the opinion of an attending Consultant and our Chief Medical Officer, the life expectancy is no greater than 12 months (or the period before the Benefit Participant ceases to be covered by the policy if sooner).

Participant's details: -

Please refer to the Data Protection Statement on page 4 for details on how we will use the Claimant's information.

The Trustees of the Scottish Police Federation Insurance Scheme in respect of:-

Full Name: _____

Date of Birth: _____ Collar Number: _____

Division: _____ Rank: _____ PSI No: _____

Home Address: _____

_____ Postcode: _____

Telephone No: _____ Home email: _____

Serving Member		Retired Member under 60	
Partner of Serving Member		Partner of Retired Member under 60	
SPF Staff		Retired member aged 60 to 63	
Partner of Police Staff		Partner of Retired member aged 60 to 63	

Claimant's Details

Full Name: _____

Address: _____

_____ Postcode: _____

Date of Birth: _____

To be completed by a Trustee or authorised signatory of the Scheme: -

I certify that the claimant is a current participant of the Scheme and that the claim details are correct. **PLEASE MAKE THE CLAIM PAYMENT TO THE TRUSTEES OF THE SCOTTISH POLICE FEDERATION INSURANCE SCHEME**

Date of Joining Scheme: _____ Date First Eligible: _____

Benefit Claimed: £ _____

Signed: _____ Date: _____

Name: _____

To be completed by the person in respect of whom the benefit is being claimed

Personal Statement

1. What illness has been diagnosed? _____

2. Have you previously suffered from or received treatment for a related illness? **YES / NO ***

If yes, give full details including dates and exact diagnosis (if known):

3. Please describe your illness in full (continue on a separate sheet if required): _____

4. On what date did you first note symptoms? _____

Date of diagnosis: _____

Date ceased work (if applicable): _____

5. Please provide full details of any tests/investigations which have been carried out (please provide name, department, reference (if appropriate) and address of the institution where such tests were performed:

6. What treatment are you currently receiving? _____

7. Please provide the name and address of your General Practitioner: _____

_____ Telephone No: _____
8. When did you first consult your General Practitioner for this condition? _____
9. Please provide the name and address of any other doctor / specialist consulted for this condition and/or details of any hospitalisation:

10. Please provide details of any other insurance policies under which you may received payment for this illness:

11. Have you ever previously claimed under this policy? **YES / NO ***
If Yes, please state condition: _____

12. Please provide any further details you feel may help us when assessing your claim: _____

*** Delete as appropriate**

Declaration

I agree with the data protection statement below detailing how my information will be used.

I declare that the information given on this form is true and complete to the best of my knowledge.

I confirm that I have been informed of my rights under the Access to Medical Reports Act and consent to the underwriters to whom the claim is submitted (the underwriters) seeking medical information from any medical practitioner who has treated me or who has access to records relating to my physical and mental health, or any other source which is necessary and relevant in the opinion of the Underwriter's Chief Medical Officer.

I do/do not* wish to see any medical reports prior to their release to the Society. I also consent to the release of such information to the Underwriter's Chief Medical Officer.

I understand and consent to the use of this information provided on this form, together with medical and other information provided in connection with any claim, for the purposes of underwriting, administration, claim management, rehabilitation and customer concern handling. In order to do this, the information may be shared with other insurers, reinsurers, insurance intermediaries and service providers.

***Delete as applicable**

Signed: _____ **Date:** _____

The settlement will be paid by BACS transfer to the Trustee's bank account, please complete the details below: -

Trustees Bank Details: -

Bank Account Name: Trust Benefit Account

Bank Account Number: 20357432

Bank Sort Code: 60-83-01

Bank Name: Unity Trust Bank

DATA PROTECTION



Philip Williams Insurance Management, confirm that the underwriter to whom the claim is submitted to is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority (Registration No. 110029) and is registered under the Data Protection Act 1998. In addition to the information gathered from you in relationship to any applications for products, the underwriter also need to maintain other records, mainly in regard to claims made on it. The underwriter maintains all the information on computer and/or paper files. Information will only be disclosed to third parties where it is necessary to do so in whatever format is considered appropriate by the underwriter, limited to:

- i. Outside consultants and agents, only as may prove necessary in developing, providing or maintaining the services of the underwriter.
- ii. Product providers, in relation to products that may be offered by the underwriter operating as an intermediary for specific products.
- iii. The Regulators (mainly the Financial Conduct Authority who have legal authority to check all of our records), or governmental agencies with the legal rights to demand disclosure.
- iv. The underwriter does not disclose information to third parties other than those stated, not lending, selling or in any other way sharing your personal information.
- v. Counselling and support services who you are willing to use and have been approved by the underwriter.
- vi. Philip Williams & Co, 35 Walton Road, Stockton Heath, Warrington, WA4 6NW, to whom claim forms should be sent.

ACCESS TO MEDICAL REPORTS ACT 1988

Rights and Procedures

Access to Medical Reports Act 1988, Access to Personal Files and Medical Reports (Northern Ireland) Order 1991

We need your consent before we can approach any doctor for a medical report about you. This is given by signing the declaration on this form. Before you sign, you should read this section carefully. It details your rights under the Act.

1. You do not have to give your consent. If you do not give your consent, we may be unable to proceed with your claim.
2. You can request to see the report before it is sent to us. We will inform the doctor that you want to see the report before it is sent to us and confirm your request in writing. You will then have 21 days to arrange with the doctor to see the report. If you haven't arranged to see the report within this period the doctor will send it to us.
3. If you indicate that you don't want to see the report, we do not have to tell you if we apply for one. You can, however, ask to see a copy of the report within six months of it being sent to us.
4. The doctor may charge you a reasonable fee if you ask to see a copy of the report.
5. If you have seen the report before it is sent to us, the doctor will require your written consent to send it to us. You have the right to ask the doctor to change anything that you consider to be incorrect or misleading. The doctor can, however, refuse to make any alterations. If the doctor refuses to change the report you may attach a note giving your views.
6. The doctor can refuse to let you see all or part of the report if, in their opinion, it is likely to:
 - Adversely affect your physical or mental health or that of others,
 - Indicate the doctor's intentions to you,
 - Reveal the identity of a third party who has given information about you unless they have consented to its disclosure or it has been supplied by a health professional involved in caring for you.

In such cases the doctor must notify you. You will only be able to see the remaining part of the report. If the whole report is affected the doctor will advise you and not send it to us without your written consent. If you refuse to give your consent we may be unable to proceed with your claim.