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, PO Box 27163, GLASGOW, G3 9EZ.

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	
Partner of Serving Member	
SPF Staff	
Partner of SPF Staff	
Retired Member under 60	
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 declare that the information given on this form is true and complete to the best of my knowledge.

Signed: _____ Date: _____

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.

Signed: _____ Date: _____

I do/do not* wish to see any medical reports prior to their release to the Society.
***Delete as applicable**

Signed: _____ Date: _____

I also consent to the release of such information to the Underwriter's Chief Medical Officer.

Signed: _____ Date: _____

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.

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 NOTICE

Philip Williams (G Ins) Management Ltd collects and uses your data in accordance with current data protection law (which includes, from 25 May 2018, the General Data Protection Regulation (Regulation (EU) 2016/679)) ("data protection law"). We maintain records in regard to policy claims on computer and/or paper files. Information will only be disclosed to third parties in whatever format is considered appropriate by us. By signing this form, you consent to Philip Williams (G Ins) Management Ltd using your data and the information you have provided to process the claim. Further information can be found in our Privacy Policy at https://www.philipwilliams.co.uk

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.

Privacy Notice

Please Note: Our Privacy Notice can be viewed on our website at www.philipwilliams.co.uk
A hard copy can be provided upon request.