Simpson House
6 Cherry Orchard Road
Croydon, CR9 6AZ
Tel: 020 8686 5050
Fax: 020 8686 5559
www.hencilla.co.uk

BECTU ACCIDENT CLAIM FORM

In the event of an insured accident, you must return this competed claim form to Hencilla Canworth Ltd, Simpson House, 6 Cherry Orchard Road, Croydon, CR9 6AZ or e-mail - bectupli@hencilla.co.uk.

IMPORTANT: claims MUST be submitted within three months of the accident.

Please ask your doctor to complete **Section C** and include with your claim form a medical certificate from your doctor explaining the exact injuries sustained, the probable cause of the injuries and the estimated time of disability. Please keep copies of all the documentation that you send to us.

Section A – to be completed by the insured person (claimant).

Please complete the following in **BLOCK CAPITALS** and provide as much detail as possible. If you are unable to fill this in yourself then it may be completed on your behalf.

Name of claimant	
Date of birth	
BECTU membership No	
Address	
Telephone	
Email	

Bank details – please provide your preferred bank details for benefit payments			
Name of account		Name of bank	
Account number		Sort code	

Please state your exact occupation.

The full name and address of the theatre, studio, location or event where the accident occurred.

The date and time of the accident.

Your activities at the time of the accident.

Please provide contact details of all witnesses and photos of the incident location where possible.

Exactly how did the accident happen? (Please continue on a separate sheet if necessary).

Please provide details of the injury.

Name of hospital (if applicable), dates of admission and discharge and the name of the medical practitioner who first attended your injuries.

The current medical practitioner responsible for your ongoing health care. Please obtain a medical certificate stating the length of anticipated disability from your usual occupation.

Please provide details of any previous injury or condition that has disabled you for a period of more than seven days in the last five years.

Have you worked since the incident occurred? If so, please provide details.

Please provide the date that you anticipate being able to return to work.

Declaration

I do hereby declare that the foregoing particulars are true in every respect and I am available for an independent medical examination if required. I further declare that the accident was not caused directly or indirectly by enemy action, intentional self-injury, intoxication or attempted suicide.

Signature of claimant Name	Date

Section B – to be completed by the insured person (claimant) – PLEASE READ CAREFULLY

Access to medical records and reports

Your consent is needed before we can apply for a medical report from your doctor, or other medical practitioner. This is governed by the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (made under the Northern Ireland Act 1974) and the Data Protection Act 1998.
In the event that you do not consent we may be unable to process your claim, or continue with benefits for a claim already in existence. If you do consent then you have a choice whether or not to see the report before your doctor, or medical practitioner, forwards it to us.
If you indicate below that you wish to see the report you will have 21 days after you have received our notification in which to contact your doctor, or other medical practitioner. If you indicate below that you do not wish to see the report but later change your mind, you are entitled to request a copy directly from your doctor, or other medical practitioner, for up to six (6) months after it has been sent to us. If you are supplied with a copy of the report your doctor, or other practitioner, is entitled to charge you a reasonable fee to cover costs. In addition, if your doctor, or other medical practitioner, spends time with you discussing your report there is an additional entitlement to charge a fee to cover the time involved as this would not fall within the NHS terms of service.
Your doctor is not obliged to let you see any part of the report if it is felt it would cause you harm, would indicate his intentions towards you or would reveal the identity or details of another person who is not a professional involved in your care.
Your doctor, or other medical practitioner, will inform you if this applies to sections of your report and you may see the remaining parts. If the whole report is affected then it will not be forwarded to us without your further consent.
You are entitled to write to your doctor, or other medical practitioner, and request that your report be amended if you consider it, or any part of it, to be incorrect or misleading. If your doctor, or other medical practitioner, is not prepared to amend your report, a statement of your views can be attached to it. Please tick the appropriate box and complete the form hereunder (where applicable) and return it to us if you provide your consent as explained above.

I wish to see the report before it is sent ☐

I do not wish to see the report before it is sent ☐

Signature of claimant	Date
Print Name	Date of birth
Address of claimant	Post code

Medical practitioners details - Name, Address, Post code

Hospital details - Name, Address, Post code

Data Protection

Hencilla Canworth Ltd and Pen Underwriting Ltd will fairly and lawfully collect and record personal information that is supplied within and as a result of this form. We shall share information with your underwriters and their agents and in certain cases, with other underwriters to help detect and prevent fraudulent claims. We require your consent to process information in this way and by completing and signing this form you are explicitly providing that consent.

Section C – to be completed by your doctor

The claimant must obtain, at his or her own expense, the following certificate from a duly qualified and registered medical practitioner.

Are you the usual medical attendant of the claimant? Yes ☐ No ☐

If Yes, how long have you been so?

On what date did you first attend upon claimant for his/her present disability?

On what date did you first sign claimant as unfit for work?

Please confirm the nature of the illness or injury sustained, together with details of the precise diagnosis and treatment being given.

Has the claimant suffered from this or any other associated complaint, prior to this period of disability?

Yes ☐ No ☐

If Yes, please give dates and types of treatment:

At the time of the accident or commencement of disablement was the claimant suffering from any other illness or disease? Yes ☐ No ☐

If Yes, please give details with medication prescribed and advise whether this will retard recovery of this new disability:

Is the disability due to self-inflicted injury, consumption of alcohol, drug abuse, childbirth, pregnancy or abortion?

Yes ☐ No ☐

If Yes, please provide details:

Is the claimant presently confined to the house? Yes ☐ No ☐

Has the claimant been confined to hospital? Yes ☐ No ☐

If so please confirm admission date/discharge date:

Did the claimant require surgery? Yes ☐ No ☐

If Yes, please advise details.

Please advise the period that the claimant was not able to work?

If the patient has not returned to work, when do you expect the claimant to be fit to return to work?

Has the claimant been confined to the house since commencement of disability? Yes ☐ No☐
If the claimant has already returned to work please state the date and whether he/she was able to return to all, or just part of his/her duties:

Declaration: I confirm that the claimant is/was under my medical attention, and was totally prevented from working for remuneration or profit from his/her normal occupation:

From		To	

Name and Signature of Doctor's and official surgery stamp.

Date