Equity accident claim form

In the event of an insured accident, you must return this competed claim form to Equity as soon as possible. Equity's address is Guild House, Upper St Martins Lane, London, WC2H 9EG.

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.

Full details of the policy cover are available at www.equity.org.uk.

Section A – to be completed by the insured person

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.

Legal name of claimant

Equity name (if different)

Date of birth

Equity number

Permanent address

Correspondence address (if different)

Telephone

Mobile

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

Please state your exact occupation:

Theatre or studio and the name of the production in which claimant was performing:

Number of performances per week at time of accident (if performing in theatre):

State the date and time of the accident:

Location of the accident:

Name and address of any witnesses to the accident:

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State what you were doing at the time of the accident:

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

Where did you first seek medical attention in relation to your injuries?

Give the name and residence of the doctor attending you for said injuries.

Doctor's name:

Doctor's address:

Where you admitted to hospital? Yes ☐ No ☐

If Yes, please provide discharge date:

State as precisely as you can what injuries you have sustained: (please enclose a medical certificate)

Are you still totally incapacitated as a result of your injuries? Yes ☐ No ☐

Have you been totally unable to attend any portion of your work? Yes ☐ No ☐

If Yes, from what date were you:

a. confined to bed

b. confined to the house

Do you receive payment from the management while you are unable to work? Yes ☐ No ☐

If Yes, for how long?

Have you suffered any condition or injury that has disabled you for a period of more than seven days in the last five years? Yes ☐ No ☐

If Yes, please give details:

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

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Please state the income you have received during the past 12 months from your Equity-related occupation:

Please advise if you have any other insurance in force to cover this event? (i.e. BUPA medical insurance)

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

Date

For Equity use

I certify that at the time of the above accident the member was in full benefit as defined in the rules of Equity.

Section B – to be completed by the insured person

YOUR RIGHTS – 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, complete the form hereunder (where applicable) and return it to us.

I wish to see the report before it is sent ☐

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

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Signature

Date of signing

Print name

Date of birth

Address

Post code

Medical practitioners details

Name

Address

Post code

Hospital details

Name

Address

Post code

Data Protection Act 1998

Van Ameyde UK 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 explicity 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.

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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 sickness 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 present disability:

Is the disability due to self-inflicted injury, consumption of alcohol, drug abuse, childbirth, pregnancy, abortion, or venereal disease or other sexually-transmitted disease or HIV related illness including Acquired Immune Deficiency Syndrome (A.I.D.S.) or A.I.D.S. Related Complex (A.R.C.)? 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:

When do you expect the claimant 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 medical attention, and was totally prevented from working for remuneration or profit from his/her normal occupation

from: to:

Signature

Doctor's official surgery stamp

Name (block capitals)

Date