

Sickness Benefit

Claim Form



Please have this form completed by yourself and your Doctor, and returned to this office within **seventy-two hours** of the **commencement** of incapacity. Failure to do so could result in loss of your benefit. Self certification certificates are not acceptable.

You should inform the Society of your incapacity as soon as possible and may use telephone, facsimile or e-mail to do so.

You have certain rights under the Access to Medical Reports Act, 1988. You should read the form of consent and follow the instructions therein.

Your attention is drawn to rules 12, 16 and 17 concerning the condition of payment of sickness benefit, especially regarding time limits for claims and travel abroad during illness.

Title (please tick) Dr. Mr. Mrs. Miss Ms

Surname _____

Forenames _____

Address _____

Date of Birth _____

Membership Number _____

Occupation _____

Contact Telephone Number during your illness _____
(Mobile Numbers not acceptable)

Nature of incapacity: _____

If the incapacity is due to an accident, please give full details

First day and time of total incapacity _____

When did you first seek medical advice about this?

If the incapacity occurred abroad, state when you returned home

Have you followed any aspects of your occupation or any other occupation since this date? (please tick) Y N

If Yes, please give details

Have you suffered from this condition before? (please tick)
Y N

If Yes, please give details

How long do you anticipate being totally incapacitated?

Name and address of your local medical attendant

Postcode _____

Name and address of any other doctor/specialist who has attended you for this ailment

Postcode _____

Please give precise details of:

1. Any sickness benefits you are entitled to under other insurance/sickness policies:

Name of insurer _____

Policy Number _____

Deferred Period _____

Weekly Benefit £ _____

2. National Insurance Benefits

Weekly Benefit £ _____

3. Retirement or Disability Pension

Name of insurer _____

Policy Number _____

Weekly Benefit £ _____

4. Any continuing income (If nil, state nil) £

5. Please state your pre-tax earnings for your financial year prior to commencement of this incapacity

£ _____

Verification of this figure may be requested at any time during your claim,

- i) for self employed members, by reference to your certified accounts and the resultant computation for taxation purposes,
- ii) for employed members, by reference to your P60 (issued by your employer).

DECLARATION

I hereby declare that I am the person referred to in the above particulars, that I have read over my replies to all the questions and that to the best of my knowledge and belief the information given above or provided separately is true and complete.

I agree to the Society seeking information in connection with this claim and authorise the giving of such information. I have been made aware of my rights under the Access to medical Reports Act 1988 and I have completed the appropriate consent form.

I understand that all questions must be answered and that failure to do so might result in a delay in processing my claim

Signature _____

Date _____

CONFIDENTIAL MEDICAL CERTIFICATE (TO BE FURNISHED AT THE EXPENSE OF THE PERSON CLAIMING)

Dear Doctor,

Completion of this form is required to substantiate a claim under an income protection insurance policy. Please complete this certificate and return it to the Chief Medical Officer, The Dentists' & General Mutual Benefit Society Limited, St. James Court, 20 Calthorpe Road, Edgbaston, Birmingham B15 1RP.

Your patient has been made aware of his/her rights under the Access to Medical Reports Act 1988. The appropriate consent form, completed by the claimant, should accompany this claim form.

If there is insufficient room to complete this section, please use the space provided at the end of this form.

Title (please tick) Dr. Mr. Mrs. Miss Ms

Surname of Claimant _____

Forenames _____

National Insurance Number _____

Date of Birth _____

Nature of incapacity _____

First day of attendance for this incapacity _____

Date of total incapacity if different from the date given above _____

Please provide the full address of any hospitals to which the insured was referred together with names of the consultant who attended.

We would be grateful for copies of any relevant hospital reports.

Is the claimant at present:

Totally unable to follow any occupation? (please tick) Y N

Confined to bed? (please tick) Y N

Able to go outdoors? (please tick) Y N

Please give details of treatment and current symptoms

Practice Stamp

Are you aware of anything in the medical history of the insured likely to be connected with the present illness? (please tick)

Y N

If yes, please give details.

Please state the probable duration of total incapacity from the date of signing this certificate.

If known, please state the date the claimant will be able to resume occupation.

I confirm that I am the medical attendant of the claimant and to the best of my knowledge the details above are accurate and complete.

Signature of medical attendant _____

Qualifications _____

Address _____

Postcode _____

Telephone _____

Date _____

ADDITIONAL INFORMATION

Is there any additional information which you feel will help with the assessment of this claim?



The Dentists' & General
Mutual Benefit Society Limited

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