

RIDER & STABLE STAFF PLAN



HIVE
Insurance Services

CLAIM FORM

HOW TO MAKE A CLAIM

To make a claim on your Rider & Stable Staff Plan, simply complete and return this claim form. We aim to pay all eligible benefits directly to your bank account. For all benefits, it will be necessary for a doctor or hospital to complete and sign a certificate too. Please note that any cost incurred must be paid by you.

Please return this form to: Hive Insurance Services, Hive Insurance Services, Office 15, Lakeview Point, Unit 24 Claregalway Corporate Park, Claregalway, Co. Galway, H91 PX38. You can also scan this form and email it to us at claims@hiveinsure.co.uk.

WHAT ARE THE QUALIFYING PERIODS?

This is the period of time immediately following your policy start date, during which you cannot claim benefits and applies to your first year of cover. You cannot claim for out of work benefit, hospitalisation benefit or fracture benefit for the first 7 days of your policy.

CIRCUMSTANCES WHERE YOU CANNOT CLAIM

There are circumstances where you cannot make a claim. These are contained in the 'what is not covered' section of your Policy Document.

IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO CONTACT CUSTOMER SERVICES ON 074 9161868.*

*Calls are recorded for training and monitoring purposes, and a record kept for regulatory purposes.

POLICYHOLDER DETAILS

Policy number:	Forename:	Surname:
Address:		Date of birth:
Eircode:		Tel (mobile):
		Tel (home):
		Email:

EMPLOYMENT DETAILS

Please complete the details below. We will need to contact your employer to confirm your employment details.

Occupation:	Employer name:	Contact name:
Employer address:		Employer tel:
Eircode:		Gross income: Weekly / Monthly €
Employer email:	How many hours per week do you work?:	Net income: Weekly / Monthly €

What benefit are you claiming for?:
 Out of work benefit Hospitalisation benefit Permanent total disability Accidental death
 Fracture benefit (please circle): Skull / Leg / Kneecap / Ankle / Arm / Wrist / Collar bone

ABOUT YOUR CLAIM

For all claims, please complete this section:

Date of accident:

Time and place of accident:

Please describe your injuries:

Please describe the accident:

What activity were you working/participating in? Where did the accident take place? What caused the accident?

Were there any witnesses? If yes please provide witness details:

Name:

Tel:

Email:

Date from which you were first unable to work:

Date from which you resumed work:

Attending doctor:

Dates:

If hospitalised, name and address of hospital:

Hospital stamp:

Dates seen at hospital:

To speed up your claim please ensure the following are completed:

OUT OF WORK BENEFIT - Doctors certificate (part 1)

HOSPITALISATION BENEFIT - Hospital certificate (part 2)

FRACTURE BENEFIT - Hospital certificate (part 2)

PERMANENT TOTAL DISABILITY - Hospital certificate (part 2). We will also need confirmation from your treating consultant.

ACCIDENTAL DEATH - Doctors certificate (part 1). We will also need a copy of the death certificate.

PART 1 DOCTORS CERTIFICATE (TO BE COMPLETED BY CLAIMANT'S GP)

What date did the patient first consult you for their accident?

Describe the accident/and injuries sustained:
(Eg. Where did the accident take place, what caused the accident etc.)

What dates did you attend the patient for this accident?

Surgery:

Home:

Hospital:

Date from which the patient was first unable to work?

Date from which the patient will be able to resume work?

Has the patient ever suffered the same or similar previously? If yes:

- Please note the date you first recorded this on your medical records:

- Please give full details including any treatment or surgery (if any):

Signature:

Date of signature:

Name:

Qualifications:

Address:

Surgery stamp:

Tel:

Email:

PLEASE NOTE: WE CANNOT ASSESS YOUR CLAIM UNLESS THE HOSPITAL CERTIFICATE AND/OR DOCTORS CERTIFICATE SECTIONS HAVE BEEN COMPLETED.

PART 2 HOSPITAL CERTIFICATE

To be completed by an authorised person - Ward Sister or Hospital Doctor

I certify that (patient's name) was admitted to this hospital
on and *was discharged on/is still in hospital *Delete as necessary

Was the patient allowed home between these dates? Yes No

If 'Yes' give details

Attending consultant

Describe the accident and injuries sustained which required hospital treatment:
Eg. Where did the accident take place? What caused the accident?

If a fracture, please tick one of the following: Skull Upper leg Lower leg Kneecap Ankle
 Upper arm Wrist Collar bone

Has the patient ever suffered the same or similar previously? Yes No If 'Yes', when (date):

Please give details including any treatment or surgery (if any):

Signed:

Position held:

Date:

Hospital stamp:

**PLEASE ENSURE THE DOCTORS CERTIFICATE IS COMPLETED BY YOUR GP ON THE NEXT PAGE TO AVOID DELAY.
THIS DOES NOT NEED TO BE COMPLETED IF YOU HAVE HAD AN ACCIDENT.**

CONSENT FOR MEDICAL INFORMATION

This only applies if we need to obtain additional information

Before giving your consent to our obtaining a Medical Report, you should read the following as it sets out your rights under the Medical Council's Guide to Professional Conduct & Ethics.

In dealing with your claim we may need to apply for a medical report from a doctor who has treated you. We need your consent to apply for this report. Before giving your consent, you should read this note carefully, as it sets out your rights. You do not have to give your consent but, if you do, you can say whether you wish to see the report before it is sent to the Company's Chief Medical Officer. If you do not give consent, we may be unable to proceed with your claim. The following information has been set out to help you.

If you allow us to seek a medical report from the doctor then you are able to say whether you wish to see the report (or have a copy of it) before it is sent to us. If you say you wish to see the report, we will tell you at the same time as we write to the doctor, and we will tell him you wish to see the report. You will then have 21 days to contact the doctor about arrangements for you to see the report. If this 21-day period elapses and these arrangements have not been made, then the doctor will send us the report.

The doctor is not obliged to let you see any part of the report if, in his opinion, it contains information that would be likely to cause serious harm to your physical or mental health or that of others, or indicate the doctor's intentions towards you or if disclosed be likely to reveal information about, or the identity of, another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional involved in caring for you. In such cases the doctor must notify you and you will be limited to seeing any remaining part of the report.

If the doctor believes that the whole report must be withheld, he will inform you and cannot send the report to us without your consent. Once you have seen the report, your written consent is again required before the doctor can submit it to us. You can write to the doctor, asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your views on any part where you and the doctor are not in agreement and which the doctor is not prepared to alter.

You may indicate that you do not wish to see the report. We can then apply to the doctor for a medical report without notifying you again. The doctor will then supply us with a medical report. If you write to the doctor asking for access while the report is being prepared, then you will have 21 days to contact the doctor about arrangements to see it. Whether or not you wish to see the report before it is sent to us, if you ask, the doctor must let you see or give you a copy of the report for up to six months after it has been supplied to us.

To be completed by main applicant

Signature:
(Main applicant)



Print name:

Date:

Name of GP:

Surgery name:

Address of GP:

Do you wish to see any report before it is sent?

Yes No

DECLARATION

It is important that you understand that any information, statements or answers made by you to us are your responsibility. You must take reasonable care not to make misrepresentations when answering our questions. If you are careless in answering our questions or deliberately make a misrepresentation, this may render the insurance void from inception (the start of the policy) and enable the insurer to repudiate liability (entitle the insurer not to pay your claims). You are advised to keep copies of documentation sent to or received from us for your own protection. Please do consult us if you are in doubt of any aspect.

I declare that the answers provided in this form and any other information provided are true and complete to the best of my knowledge.

Signature: 	Date:
Name:	Date of birth:
Address:	

PLEASE HELP US TO GO GREEN

Each year we send policyholders an annual review letter and an Insurance Product Information Document, which is a summary of key information relating to your plan. As an environmentally responsible company, we would like to ask for your permission to send you this information by email - not only will this reduce the amount of paper we use, it will also make it easier for you to manage your policy paperwork.

Please can you tick the box below to confirm you are happy to receive this correspondence by email. Sincere thanks for your support in helping us to make a difference to the environment.

I request that my annual reviews and Insurance Product Information Documents are sent to me by email:

FINAL CHECKLIST:

- Hospital and GP have completed all relevant sections, and any supporting documents are enclosed
- Employer details have been completed
- Declaration has been signed

DATA PRIVACY

Please visit the Privacy Policy page on our website, www.hiveinsure.co.uk, for further information about how and when we process your personal information.

HOW WE USE YOUR INFORMATION

The personal information, provided by you (or anyone acting on your behalf), is collected by or on our behalf and may be used by us, our employees, agents and service providers acting under our instruction for the purposes of insurance administration, underwriting, claims handling, research or for statistical purposes.

We may process your information for a number of different purposes. For each purpose we must have a legal ground for such processing. When the information that we process is classed as 'special category data', we must have a specific additional legal ground for such processing.

Generally, we will rely on the following legal grounds:

- ▶ It is necessary for us to process your personal information to provide this policy and services related to it. We will rely on this for activities such as providing you with information about your quote, assessing your application, managing your policy, handling claims and providing other services to you
- ▶ We have an appropriate business need to process your personal information and such business need does not cause harm to you. We will rely on this for activities such as maintaining our business records, developing, improving our products and services, and providing information about our products and services to you
- ▶ We have a legal or regulatory obligation to use such personal information
- ▶ We need to use such personal information to establish, exercise or defend our legal rights
- ▶ You have provided your consent to our use of your personal information, including special category data

HOW WE SHARE YOUR INFORMATION

In order to sell, manage and provide our products and services, prevent fraud and comply with legal and regulatory requirements, we may need to share your information with the following types of third parties:

- ▶ Reinsurers, Regulators and Authorised/Statutory Bodies
- ▶ Credit reference agencies
- ▶ Fraud prevention agencies
- ▶ Crime prevention agencies, including the police
- ▶ Suppliers carrying out a service on our behalf
- ▶ Other insurers, business partners and agents

MARKETING

We will not use your information or pass it on to any other person for the purposes of marketing further products or services to you unless you have consented to this.

FRAUD PREVENTION AND DETECTION

In order to prevent or detect fraud and money laundering we may check your details with various fraud prevention agencies, who may record a search. Searches may also be made against other insurers' databases. If fraud is suspected, information will be shared with those insurers. Other users of the fraud prevention agencies may use this information in their own decision making processes.

We may also conduct credit reference checks in certain circumstances. You can find further details in our full Privacy Policy explaining how the information held by fraud prevention agencies may be used or in which circumstances we conduct credit reference checks and how these checks might affect your credit rating.

AUTOMATED DECISIONS

We may use automated tools with decision making to assess your application for insurance and for claims handling processes. If you object to an automated decision, we may not be able to offer you an insurance quotation.

HOW TO CONTACT US

Please contact us if you have any questions about our privacy policy or the information we hold about you: The Data Protection Officer, Hive Insurance Services, Office 15, Lakeview Point, Unit 24 Claregalway Corporate Park, Claregalway, Co. Galway, H91 PX38.

074 9161868 | www.hiveinsure.ie

OFFICE 15, LAKEVIEW POINT, UNIT 24 CLAREGALWAY CORPORATE PARK, CLAREGALWAY, CO. GALWAY, H91 PX38

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This product is insured by Cowen Insurance Company Limited (company registration number C55905), with registered office at 380, Level 2, Canon Road, Santa Venera, SVR 9033, Malta. Cowen Insurance Company Limited is an insurance company authorised under the Maltese Insurance Business Act (Cap. 403 of the Laws of Malta) to carry on general business and is regulated by the Malta Financial Services Authority. **RSCFIRL 05/2021**