ONLYYACHT
SUPERYACHT INSURANCE

Broker at LLOYD'S

CREW WELFARE CLAIM FORM

PLEASE COMPLETE APPROPRIATE SECTIONS - FULLY FAILURE TO DO SO MAY DELAY THE PROCESSING OF YOUR CLAIM

☐ Accident ☐ Illness ☐ Loss of Property

1. **PERSONAL DETAILS & BANK DETAILS FOR REIMBURSEMENT**	
Vessel's Name:	Position:
	☐ Permanent Crew Member ☐ Temporary Crew Member
Claimant's Name:	Date Employment commenced:
Date of Birth:	Telephone Number:
Nationality:	Email Address:
Home Address:	
Benificiary Name:	
Bank Account Currency:	
SWIFT / BIC code:	
IBAN/ Account number:	
Sort Code / ABA (if applicable):	

PLEASE COMPLETE EITHER SECTION 2, SECTION 3 or SECTION 4

2. **ACCIDENT**
a. Date of accident:
b. Place of accident:
c. How did the accident occur?:
d. Injury sustained:
e. Is it aggravation of earlier sustained injury? YES ☐ NO ☐
f. Witnesses' names and addresses:
Description / Details :
DOCTOR'S DETAILS
a. Name and address of usual doctor:
a. Name and address of doctor consulted in respect of this claim:

3. **ILLNESS**
a. Diagnosis:
b. When did the symptoms first appear:
c. Have you suffered from this complaint before: YES ☐ NO ☐ c-1 If yes please provide details: Dates:
d. Where you hospitalized as an in-patient: YES ☐ NO ☐ d-1 If yes please provide details: Date Admitted: Date Discharged:
Description / Details
DOCTOR'S DETAILS
b. Name and address of usual doctor:
b. Name and address of doctor consulted in respect of this claim:

4. **LOSS OF PERSONAL PROPERTIES**	
Description / Details	Reparable Item: YES ☐ NO ☐
Copy of invoice	
Photo of damaged items	

5. **OTHER INSURANCE**
a. Do you hold any other insurance that may cover this loss? YES ☐ NO ☐
b. Are you eligible to any National Health Cover in your country of domicile? Y E S ☐ N O ☐
if answer is YES (to a or b), please provide details:

6. MEDICAL & TRAVEL EXPENSES

Invoice Number	Date	Supplier	Type of Service Provided	Cost

If medical expenses were incurred, please list and submit each original invoice for which a claim is being submitted: When you attend the doctor, please request medical report. All medical reports and invoices available need to be attached to this form.

DECLARATION

I declare that the information on this form and any supporting documentation is true to the best of my knowledge.

Name: Signature: Dated:

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CLAIM FORM - Personal Accident / Illness

ACCESS TO MEDICAL REPORTS ACT 1998 / Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 / Access to Health Records and Reports Act 1993 (Isle of Man) ("The Acts").

To enable us to assess your claim, it may be necessary to obtain medical evidence.
Any reports which are requested from your doctors are subject to the Acts. Please note that reports requested from doctors appointed by the Insurance Company are not subject to the Acts. In summary, your statutory rights are as follows:

1. A medical report cannot be requested from any doctor who has attended you, without your written authority.
2. You do not have to give your consent. If you do consent, you can say whether you wish to see the report before it is supplied. If you do not give consent we may be unable to proceed with your claim.
3. If you wish to see the report, we will write to your doctor and tell them and advise you that we have done so. You will then have 21 days from the date of notification to contact the doctor to make arrangements for you to see the report.
4. The medical practitioner will be informed that you wish to have access to the report and will allow 21 days from the date of notification for you to see and approve it before it is supplied to us. If the medical practitioner has not heard from you on writing within 21 days of the application for the report being made, he/she will assume that you do not wish to see the report and that you consent to it being supplied.
5. If you say that you do not wish to see the report, we do not have to notify you if we apply for one.
6. Whether or not you say you wish to see the report before it is sent to us, you may ask your doctor to show you a copy of the report for up to 6 months after it is supplied. The practitioner may charge you a reasonable fee for the cost of supplying a report.
7. If you see a report before it is sent to us, the doctor cannot submit it until you give your consent. You can write to the doctor asking that any part of the report which you consider to be incorrect or misleading be amended and to have attached to the report a statement of your views.
8. The doctor is not obliged to let you see any part of the report if:
   a) in his/her opinion it would be likely to cause serious harm to your physical or mental health, or that of others.
   b) it would indicate the doctor's intentions towards you.
   c) disclosure would be likely to reveal information relating to, or the identity of someone else that has supplied information about you, unless that person has consented.

DECLARATION

THIS MUST BE READ AND SIGNED BY THE PERSON MAKING THE CLAIM

I hereby authorise any physician or other person who has attended or examined me to furnish the Company or its authorised representatives with any and all information with respect to any illness, sickness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records.

I do ☐ do not ☐ wish to see a copy of the medical report before it is sent to the Company (please tick). A photocopy of this authorisation shall be as effective and valid as the original.

I declare that the statements on this or any related form and document are true and correct to the best of my knowledge and belief and have not knowingly withheld any information connected with this claim. I agree to provide the insurer with any further information as may be reasonably required and understand the insurer does not admit liability by issue of this or any related form.

DATA PROTECTION
I understand that, in accordance with applicable regulations (the GDPR EU 2016/679 of 27 April 2016), you will not discuss my claim with anyone else without my permission (including my spouse, any relative or friend, or legal advisor) unless I provide their name below. For security I understand you will ask them to verify their identity by confirming by date of birth, postcode and policy number.

NAME _____ RELATIONSHIP _____

I understand that you may share information about me including but not limited to medical reports, private investigators reports and rehabilitation co-ordinators reports where appropriate including:
My employer or my employer's intermediary. My nominated General Practitioner.
Third parties - including but not limited to The Association of British Insurers, trustees in bankruptcy, re-insurers, underwriters, medical agencies (in the UK and abroad), subcontractors and agents.
Insurance reference agencies - this information will be used by other agency users in assessing insurance risk and fraud prevention.
Government regulators and the Financial Ombudsman.
Other insurance companies who require information for lawful purposes.

I understand all calls are recorded for training purposes, quality control and for the monitoring of fraudulent claims.

I understand that I am entitled, without excessive delay, to access my information and to rectify any inaccuracies at any time by writing to you.

The insurance industry operates a number of anti-fraud initiatives. I understand that the information given on this form may be stored electronically and may be shared with other organisations for this purpose. I understand that you may ask for information from other organisations to check the answers I have provided. I understand that the making of a fraudulent or knowingly exaggerated claim is a criminal offence and that you investigate all cases and any person suspected of fraud is reported to the police with whom the insurer always cooperates.

Claimants signature: _____ Print name: _____ Date: ___ / ___ / ___