William Russell

Global Health Plans

Accident Claim Form

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email, or post. You can find our contact details at the end of this form.

Your personal details

Full name: ..... Plan number: .....

Address: .....

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Date of birth: ..... Email: .....

Mobile number: ..... Home number: .....

Your regular physician's details

Name of physician: ..... Title: .....

Address: .....

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..... Email: .....

Telephone number: ..... Fax number: .....

Circumstances of your accident

Please describe the circumstances of the accident, including the date and time of the accident. Please continue on to a supplementary sheet if necessary.

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Important information relating to the accident

Were you under the influence of alcohol at the time of the accident? ◯ Yes ◯ No

If **YES**, please confirm the units of alcohol consumed: .....

Were you under the influence of drugs (including prescribed medication) at the time of the accident? ◯ Yes ◯ No

If **YES**, please confirm the name of the drugs taken: .....

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Prior to the accident, when did you last consume any alcohol? Date: ..... Time: .....

How many units of alcohol did you consume? .....

Prior to the accident, when did you last take any drugs (including prescribed medication)? Date: ..... Time: .....

What were the names of the drugs taken? .....

Accident reports

Please provide full contact details of any witnesses: .....

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Witness

Please provide the names and contact details of all officials (including police) to whom the accident was reported: .....

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Other Parties

Please provide full details of any other parties involved in the accident or who may have contributed to the accident: .....

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Injuries

Please describe your injuries: .....

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Previous incidents

Have you ever suffered from any similar injuries or been involved in any other accidents in the past? ◯ Yes ◯ No

If **YES**, please provide full details of the accident circumstances, including dates and the contact details of the physician(s) who treated you:

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Declaration and consent

I hereby declare that, to the best of my knowledge, all information provided in this form is accurate and complete. I hereby authorise any physician, doctor of medicine, hospital or other person who has attended or examined me, to furnish to William Russell Limited or to their authorised representative any and all information with respect to sickness or injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records relating to me (or to the claimant if I am the claimant's parent or legal guardian).

I accept that my personal details may be passed to selected third parties, such as cost agents and administrators, for the sole purpose of assisting with the administration of my claim.

I hereby give William Russell Limited authorisation to correspond with me by email regarding my claim. I understand that these emails may contain reference to my medical condition(s) and financial payment information.

Name of claimant*: .....

Signature of claimant*: ..... **Date:** .....

**This should be completed by the claimant's parent or guardian if the claimant is a child under 16 years of age, or by the claimant's next of kin if the claimant is unable to provide properly informed consent due to cognitive disability, or if the claimant is deceased. Please state your relationship to the claimant and your contact information.*

William Russell Ltd.
William Russell House
The Square, Lightwater
Surrey, GU18 5SS, UK

T +44 1276 486460
E claims@william-russell.com
william-russell.com

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