Personal Accident Claim Form

SPORTSCOVER DIRECT®

ALSO FOR USE IN RESPECT OF CLAIMS FOR: DENTAL & OPTICAL TREATMENT, HOSPITALISATION OR LOSS OF SHOOTING EVENT FEES

Please return the completed form to: shooting@woodgate-clark.co.uk

Personal Details	
Full Name:	
Policy/Membership Number:	
Occupation (including part-time):	
Postal Address:	
Daytime Telephone Number:	
Email:	
Incident	
Address where incident occurred:	
Date and time of incident:	

Full details of Incident which resulted in injury:	
Total Amount Claimed/ Indication of Costs:	

Please confirm the nature of the injuries you sustained:	
Have you ever had this injury, or similar injury, in the past:	
If yes, when & please provide full details:	
When did you first consult a Doctor?	
Name & address of Doctor consulted:	
Name & address of your usual family Doctor:	
Please provide names and addresses of any witnesses.	

If claiming Dental or Optical treatment:

Please provide written confirmation from a qualified dentist or optician that the injury is as a direct result of the incident described above, along with original receipts for treatment

If claiming Hospitalisation:

Date admitted to hospital (please provide copy admissions form)	
Name and address of hospital attended:	
Date discharged (please provide copy discharge form):	

If claiming Loss of Shooting Event Fees:

Please provide evidence of your pre event registration and evidence that entry fees having been paid to the organiser and written confirmation that they are non-refundable

Name, address and date of the event which you were unable to attend	
The date when you entered the event .	

Where applicable, claims cannot be settled until all treatment relating to the injury has been completed.

It is necessary that great care should be taken in the completion of this form and the information you give should be strictly accurate irrespective of whether it is in your favour.

Persons found to have lodged a fraudulent claim are liable for prosecution.

The issue and acceptance of this form does not constitute an admission of liability by Underwriters.

I/We declare that the above statement and facts are to the best of my/our knowledge true, and that I/We have not withheld from the Company any information within my/our knowledge connected with this claim.

Signature of Claimant:		Date:	

Forward to: Woodgate & Clark Ltd
The Red House, King Street,
West Malling Kent ME19 6QT

WE MUST RECEIVE THE COMPLETED CLAIM FORM WITHIN 30 DAYS OF THE EVENT
Failure to do so may prejudice your claim

Consent for Release of Medical Records

	OUR RED: SS/HZ/50-
Full Name (including any former name):	
Date of Birth:	
Date of Accident:	
Address and Postcode (including former address if changed since accident)	
Contact Telephone Numbers:	**Home:**
	Work:
Hospitals Attended (if known please give Record Number on appointment card and name of Consultant attending):	
General Practitioners Name and Full Postal Address:	

- **I consent to the disclosure of my complete Medical Records, X-rays and other scans to: Woodgate & Clark Ltd The Red House, King Street West Malling Kent ME19 6QT, and any medical adviser instructed on their behalf.**

- **I confirm that no litigation against the medical providers, their Servants or Agents is intended.**

Signed:		Date:	

This request is in accordance with the General Data Protection Regulation 2018. We confirm that we are prepared to meet the access fee of £10.00, together with the appropriate photocopying and postal charges pursuant to this Act.

Forward to: Woodgate & Clark Ltd The Red House, King Street West Malling Kent ME19 6QT