



# SCHOOLTEACHERS FRIENDLY SOCIETY

Authorised and regulated by the Financial Services Authority

30 Mather Avenue  
Liverpool  
L18 5HS

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Dear Member,

This is the Internet version of our Claim Form.

**It consists of 4 pages, but only pages 2, 3 and possibly 4 need to be sent to us.** This page (Page 1) is for your information only.

It is very important that all three pages sent to us have all parts and questions fully answered, as your claim cannot be assessed with incomplete information. Page 4 can be omitted if sending an original medical certificate.

**Claimant's statement: (Page 2)** – All claimants must complete questions 1 to 11 inclusive, and sign the declaration at the bottom of the page.

**Consent to obtain a Medical Report: (Page 3)** – Please read and understand your rights, then sign the Claimant's Consent indicating whether or not you wish to see any report requested.

**Doctor's Statement: (Page 4)** – **This need only be completed by your Medical Practitioner if you are not enclosing an original (not photocopied):-**

- or Doctor's Statement (Form Med 3)
- or Hospital Certificate (Form Med 10)
- or DSS Certificate (Form BF30)

If you wish the Medical Certificate to be returned to you, or forwarded to another address, please enclose a stamped addressed envelope.

**Please note that any fee payable for a medical certificate is at the expense of the member, and not the Society.**

Please use the content of this page as a 'checklist' when sending your forms (and any medical certificates) to us in the post. If you have any questions regarding your claim, please either contact the Claims Department during normal office hours, or Email us on [info@schoolteachers.org.uk](mailto:info@schoolteachers.org.uk).

Yours sincerely,

Claims Department

# CLAIMANT'S STATEMENT

1	Surname	Title
	Forenames	
	Membership No.	
	Agency:	

2	Home Address:	
	PostCode	Tel. No

3	Occupation:
	If retired, please state date of retirement and whether normal, early, or for medical reasons

4	Name and address of employer (if applicable)
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5	Name and address of General Practitioner
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6	On what date were you first medically certified unfit for your occupational duties?
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7	What is the exact nature of your incapacity?
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8	Have you engaged in any work since your incapacity began?
	If 'yes' give details:

9	Are you entitled to any other disability benefits from any other insurer?
	If 'yes', please give the Company, address and policy number(s):

10	Please give the date you returned, or expect to return to your normal occupation:  _____ / _____ / _____
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11	Has your incapacity ended and is this your full claim?
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## **DECLARATION – To be signed by the Claimant**

I declare that the information given in the Claimant's Statement is true and complete to the best of my knowledge and belief. I authorise my employer to provide all necessary information as required by the Society for this claim.

**Data Protection:** By returning this completed form to Schoolteachers Friendly Society you consent to our processing sensitive personal data about you where this is necessary for the purposes of underwriting and processing your claim for benefit. This information will also be used for the administration of your membership and in conjunction with any future requests to increase your rate of contribution or claim benefit. This information may be disclosed to our advisers and reinsurers for the purpose of underwriting, processing and claims handling, and also to our representatives to keep them informed of your membership account and to enable them to assist you should you wish to contact them direct with any queries. Information other than medical and claims records may be used for marketing purposes and our representatives may contact you by mail and/or telephone with marketing material which we feel may be of interest to you. If you do not want to be contacted by Schoolteachers Friendly Society with their marketing literature please tick this box  You have the right to ask for a copy of the information we hold about you (for which we may charge a small fee) and to correct any inaccuracies in your information.

Signature	Date
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# **CONSENT TO OBTAIN A MEDICAL REPORT**

## **CLAIMANT’S RIGHTS – To be read by the claimant**

Please read the information given below which explains your rights under the Access to Medical Reports Act 1988 and sign the Consent to obtain a medical report. Under the rules of the Society, we may require you to be medically examined (at our expense) or seek medical information from your own or from any other doctor who has attended you. Signing the Consent now will save time later and we want to be able to deal with your claim as quickly as possible.

You do not need to give your consent to our Medical Adviser being provided with medical information but if you do, you have the right to tell the doctor that you wish to see the report before it is sent to us. If you express a wish to see the report, the doctor cannot send it to us unless either he has shown it to you or 21 days have passed without you having contacted your doctor about arrangements to see it.

Of course, the quicker you act, the quicker your claim can be considered and we will not be able to proceed with your claim in the absence of medical information.

Whether or not you say you wish to see the report before it is sent to us, the doctor must let you see a copy of it for up to six months after it is supplied, if you ask. If you do ask the doctor for a copy of the report, you can be charged a reasonable fee to cover costs.

Once you have seen a report before it is sent to us, the doctor cannot submit it until you give your consent. You can write to your doctor asking to amend any part of the report which you consider to be incorrect or misleading. You may also 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.

The doctor is not obliged to let you see any part of the report if, in his opinion, that would be likely to cause serious harm to your physical or mental health or that of others; or would indicate the doctor’s intentions towards you; or if disclosure would 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 it is the whole report which is affected, he must not send it to us unless you give your consent.

## **DOCTOR’S NOTES – To be read by the Doctor completing this report**

Under the Access to Medical Reports Act 1988, certain legal requirements have to be complied with by both insurers and any doctor who has responsibility for the health care of any individual making a claim.

The Claimant must have given consent for us to approach you and this consent is below. This consent indicates whether the Claimant wishes to see the report before it is sent to us.

If the Claimant has said that he/she does not wish to see the report, there is no need to delay. Please send the report to the address given at the end of this form.

If the Claimant has elected to see the report, he/she has been told that he/she has 21 days to make an appointment with you to see the report.

You have the right to withhold the report or part of it from the Claimant if you consider it might be harmful and, if in doubt, you may wish to take advice from your Medical Protection Society or Defence Union on this matter.

If, after 21 days, he/she has not approached you, you should send the report to the address given at the end of this form.

Please keep a copy of this report for your records as the Claimant has the right during the next six months to see it, for which you may make a reasonable charge.

## **CLAIMANT’S CONSENT – To be signed by the Claimant**

I have been informed of my statutory rights under the Access to Medical Reports Act 1988, and in connection with my insurance claim, hereby consent to The Schoolteachers Friendly Society being provided with medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health, and I agree that a copy of that consent shall have the validity of the original.

I wish to see the report before it is sent to the Society

I do not wish to see the report before it is sent to the Society

Signature	Date
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# DOCTOR'S STATEMENT

To be completed by a qualified and registered Medical Practitioner  
and supplied at the expense of the claimant

<b>1</b>	Patient's Surname	Title
Forenames		

<b>5</b>	Is the patient suffering from any other condition or disability? If so, please give details and indicate to what extent it affects the present disability.
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<b>2</b>	Please give details of: - Diagnosis  - Treatment  - Operations performed  Was alcohol a contributory factor?
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<b>6</b>	Please state dates the patient was: Unable to perform any part of his/her occupation:  Able to perform part but not all functions of his/her occupation:  If currently unable to perform any part of his/her occupation, please state the reason for this:
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<b>3</b>	For what period was the patient:  In hospital?  Confined to bed?  Confined to home?
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<b>7</b>	If the patient is still not fit for work, when do you think he/she will be able to resume his/her occupation?  Approx. date: ____/____/____
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<b>4</b>	Please state:  Date treatment first sought ____/____/____  Date of last visit ____/____/____  Total Number of visits _____
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<b>8</b>	Is the illness/injury expected to leave any residual effect?
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## **DOCTOR'S DECLARATION – To be signed by the Doctor**

**I declare that the information given in the Doctor's Statement is true and complete to the best of my knowledge and belief.**

Signature	Date
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Practice Stamp
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Please return this completed form to:  
Schoolteachers Friendly Society, 30 Mather Avenue, Liverpool L18 5HS