PELIWICA INSURANCE

Date Received	For Peliwica Ltd use only

CLAIM FORM FOR PERSONAL ACCIDENT and PUBLIC LIABILITY.

Are you completing this form for: (please tick the appropriate box)

Personal Accident (and Dental) ☐ (Please complete sections 1,2,3, 4 and 6)

Public Liability ☐ (Please complete sections 1,5 and 6)

WE'RE HERE TO HELP!

If you have any queries, please call us on **01423 593335**, email us at **claims@peliwica.com** or visit our website **www.peliwica.com**

We will contact you in 5 working days once we receive your claim form to give you an initial progress update

- **Please read you policy schedule to check your sections of cover and indemnity limits.**
- Please send all completed claims forms and/or supporting documentation to claims@peliwica.com

1 Policyholder or Broker to complete About You

What is your policy number? ……

Policyholders Name……

Policyholders Address……

……

…….. Postcode……

Email Address……

Contact Phone Number ……

2 Policyholder or Broker to complete Personal Accident and Dental

Name of the Horse involved ……..

Please provide the date and time of the incident

Date ……. /……/…… Time …… am/pm

Address/Location of the incident

Address……..

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…….. Postcode……

Please describe fully the circumstances of the incident

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Please provide details of the injury(s) sustained (if you have any medical reports, please provide these)

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Please provide the name and address of the person and/or witness(s) who discovered the Theft and/or Damage (if different from the policyholder name and address in part 1) (if more than one please use separate paper)

(Witness) Name……

Address……..

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…….. Postcode……

Email Address……..

Contact Phone Number ……..

3 To be completed by the Doctor / Dentist Personal Accident and Dental

Please provide the name and address of the patient

Patient Name……

Address……..

……..

…….. Postcode……..

Are you the patients usual medical practitioner / Dentist? (please tick)

Yes ☐ **No** ☐

If yes, how long has the patient been registered with your practice? ……

When did you first attend to the patient regarding the incident being claimed for?

……/……/……

Diagnosis of the Injury (if a diagnosis has not yet been reached, please advise of the clinical signs and the exact areas affected)

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Will the injuries give rise to any of the following? Please tick as appropriate

Item 1: **Death from an accident**				
Item 2: **Permanent blindness in one or both eyes**	**Yes**	☐	**No**	☐
Item 3: **Loss of limb: one or both hands or arms**	**Yes**	☐	**No**	☐
Item 4: **Loss of limb: one or both feet or legs**	**Yes**	☐	**No**	☐
Item 5: **Permanent total disablement**	**Yes**	☐	**No**	☐
Item 6: **Dental Treatment**	**Yes**	☐	**No**	☐

If yes answered to any of the questions, please provide full details……
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Are there any aspects of the insureds previous medical/dental past which may have a bearing on this claim? (please tick)

Yes ☐ **No** ☐

If yes, how long has the patient been registered with your practice? ……

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Has treatment finished? (please tick)

Yes ☐ **No** ☐

Please state the total cost of the injured person's treatment or estimate if treatment not yet concluded (deleting any treatment cost unrelated to the accident)

£……

Please provide the name and address of the treating practice

Practice/Surgery Name ……

Address……

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…… Postcode……

Email Address……

Contact Phone Number ……

Please state your professional qualifications

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4 To be completed by the Doctor / Dentist Declaration

- **I have checked the information on this claim form and can confirm that in my professional opinion it is accurate and correct**
- **The fees that I have charged are no higher than my normal fees**
- **I will provide the client with a copy of this form and all invoices claimed for.**

Name ……

Position in Practice……

Contact email address……

Please sign and date in this box and provide a practice stamp (if available)

5 Policyholder or Broker to Complete Public Liability

ANY LETTER OR DOCUMENT YOU RECEIVE SHOULD BE PASSED TO US IMMEDIATELY AND UNANSWERED

Please give full details of any other Liability Insurance that you hold (include Company name and policy number if available)

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Please provide the name and address of the complainant

Name……

Address……..

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…….. Postcode……

Email Address……..

Contact Phone Number ……..

Please provide the date and time of the incident

Date …….. /……/…… Time …….. am/pm

Name of the Horse involved ……..

Please describe fully the circumstances of the incident

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If the incident was in relation to a road or public highway, please answer the following and support with a diagram/ drawing or map of the occurence

Weather and road conditions ……

Width of road at point of impact ……

Type of road surface at point of impact ……..

Details of the Police Officer, Station and the date and time if they were notified/involved?

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Date ……. /……/…… Time ……. am/pm

Please provide the Crime Reference Number that was allocated?

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What do you think caused the horse to behave in this manner?

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Please provide the name and address of any witness(s) (if different from the policyholder name and address in part 1) (if more than one please use separate paper)

(Witness) Name……

Address……..

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…….. Postcode……

Email Address……..

Contact Phone Number ……..

6 To be completed by the Policy holder only Declaration

By Signing this declaration, I confirm that I have checked all the information on this form and confirm that it is correct and true to the best of my knowledge.

I also confirm that Peliwica Ltd may contact my previous insurance provider to obtain information they may be required in the handling of my claim

Please sign and date below