



The Medical Insurance Advisory Bureau

Staff Absence Insurance Claim Form

PERSONAL DETAILS

Full Name of Claimant	
Name of Insured Practice (if relevant)	
Address & Postcode	
Telephone (Business Hours)	
Occupation of Claimant	
Date of Birth of Claimant	
Please provide details of hours worked (please complete on a separate sheet if required)	Sunday: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Total:



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SECTION ONE

If this claim relates to **SICKNESS, INJURY** or **PERSONAL ACCIDENT** please complete the following section, otherwise please proceed to section two

<p>Please describe your illness/injury in full (continue on a separate sheet if required)</p>	
<p>On what date did you first notice the symptoms of your illness or on what date did the injury occur?</p>	
<p>When did you contact your doctor about this condition?</p>	
<p>Please confirm the first day you were absent from work as a result of this illness/injury</p>	
<p>Please confirm the last day you were absent from work as a result of this illness/injury (if known)</p>	
<p>Have you contacted any other medical practitioner about this condition?</p> <p>If so, please give names, addresses and dates</p>	
<p>Please provide details of any tests that have been carried out (please provide name, department, reference and address of institution where such tests were performed)</p>	
<p>What treatment are you currently receiving?</p>	



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<p>Have you previously suffered from the same or any similar condition?</p> <p>If so, please provide full details including dates</p>	
<p>Name and address of your current Doctor</p> <p>Telephone number</p>	

SECTION TWO

If this claim relates to MATERNITY LEAVE please complete this section, otherwise please proceed to section three

<p>Date(s) of Birth of Child(ren)</p>	
<p>Dates of Maternity Leave</p>	<p>FROM:</p> <p>TO:</p>

SECTION THREE

If this claim relates to PATERNITY/ADOPTION LEAVE please complete this section, otherwise please proceed to section four

<p>Date(s) of Birth of Child(ren) or Date Adoption Commenced</p>	
<p>Dates of Paternity or Adoption Leave</p>	<p>FROM:</p> <p>TO:</p>



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SECTION FOUR

If this claim relates to BEREAVMENT LEAVE please complete this section, otherwise please proceed to section five

Dates of bereavement leave	FROM: TO:
Please detail the circumstances for bereavement leave	
Name of the individual who approved bereavement leave	

SECTION FIVE

If this claim relates to SUSPENSION please complete this section, otherwise please proceed to section six

Dates of suspension from duty:	FROM: TO:
When did the claimant and/or the Insured Person become aware of the investigation in to the suspension?	
What is the reason for the suspension? (please continue on separate sheet if necessary)	

SECTION SIX

If this claim relates to JURY SERVICE please complete this section, otherwise please proceed to section seven

Dates of jury service	FROM: TO:
Total days served	



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SECTION SEVEN – DOCTOR’S STATEMENT – This section must be fully completed by the attending Doctor – The costs for the completion of this section is not the responsibility of MIAB or the insurer.

SECTION	DOCTOR'S STATEMENT
Patient's Name	
Date of Birth	
Please give full details or the injury or illness	
Final diagnoses	
When did the patient first receive medical attention for this condition?	
Has the patient ever suffered with this or any similar condition before the present episode?	
If yes please give details including dates, treatment and consultation	
Are you the patient's usual Doctor?	
If no please give name and address of usual Doctor	
From what date was the patient unable to work?	
Is the patient still unable to work	
If yes when will the patient be able to return to work?	
If no when did the patient return to work?	



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Doctor's signature	
Date signed	
Name	
Address	
Telephone Number	
Validation Stamp	

Thank you for your assistance in completing this form



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SECTION EIGHT – REQUIRED DOCUMENTATION CHECKLIST

SECTION	REQUIRED DOCUMENTATION
1 – Illness, Injury or Personal Accident	<input type="checkbox"/> Medical Certificate(s) <input type="checkbox"/> Doctor's Statement
2 – Maternity Leave	<input type="checkbox"/> MATB1 form (certificate formally confirming pregnancy and expected due date)
3 – Paternity / Adoption Leave	<input type="checkbox"/> Copy birth certificate or confirmation of the adoption from appropriate government agency.
4 – Bereavement Leave	No further information required
5 – Suspension	<input type="checkbox"/> Copy of suspension report
6 – Jury Service	<input type="checkbox"/> Copy of original summons letter <input type="checkbox"/> Certificate of Attendance from Jury officer at the Court



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DECLARATION

Any omission or mis-statement of a material fact in this form could affect the payment of benefits from the above numbered plan. A material fact is one which is likely to influence the assessment of this claim.

Insurers and their agents share information with each other to prevent fraudulent claims and for underwriting purposes via the Claims and Underwriting Exchange register, operated by Database Services Ltd. A list of participants is available on request. The information you supply on this form, together with the information you have supplied on your application form and other information relating to the claim, will be provided to participants.

I/We declare that the particulars given on this form to AXA Insurance UK plc are true and complete.

I/We understand that you may seek information from other insurers to check the answers I/We have provided.

I/We consent to AXA Insurance UK plc seeking information from any of the doctors, medical institutions or medical practitioners referred to above and I/We hereby authorise the giving of such information

SIGNED (Insured Person)	
Date	
SIGNED (On behalf insured practice)	
POSITION	
Date	
N.B. The person signing on behalf of the practice must be authorised to do so.	

Claim payments will be made in the name of the policyholder, if an alternative is required please confirm	
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FOR MIAB OFFICE USE ONLY:

POLICY NUMBER:	
INCEPTION DATE:	
WEEKLY/MONTHLY BENEFIT:	£ per week/month (delete as applicable)
DEFERRED PERIOD:	