www.pgmutual.co.uk

Income Protection Plus

Income Benefit Claim Form

Please note:

- You must complete and return this form to PG Mutual within the appropriate notice period for your policy or any benefit you may be entitled to could be **deducted for each day the form is not received**. This notice period is 14 days for all Members unless you have a Claim Deferment Period of 3, 6 or 12 months, in which cases the notice period from the first day of your incapacity will be 28 days or 3 months respectively.
- You will not be entitled to receive any Income Protection claim benefit until this form and the supporting evidence has been received and approved by PG Mutual.
- PG Mutual does not accept liability for any costs you may incur in respect of your making a claim for Income Benefit. This includes any costs you incur obtaining supporting evidence of your incapacity or your income.
- We do not accept medical certification from a member of your immediate family.

pg mutual
income protection plus

Completing This Declaration:

✓ **DO READ THIS FORM IN FULL BEFORE COMPLETING IT**

✓ Do complete this form in **BLOCK CAPITALS** and use **blue** or **black** ink

✓ Do ensure that all required applicable sections are answered in **full**

✓ Do ensure that **Material Facts** to your claim are **disclosed** in **full**.
A **Material Fact** is a fact likely to influence PG Mutual's assessment or acceptance of this claim

✓ Do ensure that any requested supporting documentation is provided

✗ Do not give **false, fraudulent** or **incomplete** information

✗ Do not provide **illegible** or **difficult to read** answers or documentation (as this may cause a delay in the assessment of your claim)

Please note: Failing to comply with the above will lead to your claim being delayed or possibly declined.

Your Policy Details Summary (For Office Completion Only)

Membership Number

_____

Level of Weekly Benefit

£ _____

Long-Term Benefit Level (Delete as appropriate)

Standard Cover

Premium Cover

Policy Exclusions (Other than the standard policy exclusions)

_____

_____

_____

Claim Deferment Period (Delete as appropriate)

No Deferment Period

7 days from commencement of incapacity

14 days from commencement of incapacity

1 month from commencement of incapacity

3 months from commencement of incapacity

6 months from commencement of incapacity

12 months from commencement of incapacity

1. Your Contact Details

1.1 Full name and title:

Home address:

Postcode:

Work address:

Postcode:

1.2 Contact numbers and email:

Home telephone number:

Mobile number:

Work telephone number:

Email address:

Please note: We particularly need your home landline number.

2. Your Income Details

2.1 Employer Sickness Pay

(If you are not employed, please proceed to the next question)

Are you entitled to sickness pay from your employer excluding State Sickness Pay (SSP)?

Yes ☐ No ☐ (tick as appropriate)

If yes, please give details, (e.g. 100% for six months, then 50% for following six months):

2.2 Your income

Employed

Do you work a. Full-time? ☐ b. Part-time? ☐

How many days do you work per week?

What days of the week do you work?

How many hours per week does this amount to?

Gross annual salary as declared for tax purposes: **£**

To calculate income, employed directors may include dividends and emoluments from this directorship.

Please state the nature of the business they come from:

What is your job title?

Self-Employed

Do you work a. Full-time? ☐ b. Part-time? ☐

How many days do you work per week?

What days of the week do you work?

How many hours per week does this amount to?

How long have you been self-employed?

Please state your share of any business pre-tax profits after deduction of business expenses (the amount chargeable to tax under classes I and II of the Income and Corporation Taxes Act 1988) over the last 12 months:

£

Previous year (estimated, if accounts not yet available):

£

If self-employed for less than one year, state previous earnings before becoming self-employed:

Last year **£** Previous year **£**

Notes:

Please note: You may be asked to provide evidence of your income when you return your Claim Form. This will normally be your last three payslips if employed and/or your last submitted tax return to HMRC.

2.3 If you are a Locum, please complete this section

On average, how many hours do you work per month?

How many hours have you worked in the last month?

On average, how many days do you work per week?

If self-employed for less than one year, state previous earnings before becoming self-employed:

Last year **£** Previous year **£**

Name, address and contact details of the premises where you were working immediately prior to your incapacity?

Name:

Address:

Postcode:

Telephone number:

Email address:

Date when you last worked there:

Name, address and contact details of the premises where you plan to work in the near future on your return to work:

Name:

Address:

Postcode:

Telephone number:

Email address:

Date(s) when you plan to start working again:

Name, address and contact details of the premises where you had work booked but had to cancel because of this incapacity:

Name:

Address:

Postcode:

Telephone number:

Email address:

2.4 Other Insurance Policies

Are you eligible to receive an income from any insurance policy as a result of this accident or illness (excluding this Income Protection Plan)?

Yes ☐ No ☐ (tick as appropriate)

If you do have any such insurance policies, please give details of the policy or policies, including:

a) The name of the insurer and policy number

b) The level of income you will receive

c) How long the policy will pay you this income for, and

d) What claim deferment period applies

3. The Cause of your Capacity

Has your incapacity been caused by any of the following?

Intentional self-injury	Yes ☐	No ☐
Surgery for cosmetic purposes	Yes ☐	No ☐
Being under the influence of alcohol or drugs	Yes ☐	No ☐
Disorderly conduct, criminal acts or omissions	Yes ☐	No ☐
Your wilful participation in riot or civil commotion	Yes ☐	No ☐
Your participation in any hazardous activities	Yes ☐	No ☐
Reactive depression or anxiety	Yes ☐	No ☐
Any other mental, nervous psychotic or psychoneurotic deficiencies	Yes ☐	No ☐
Any reactive disorder arising from the illness, death, injury etc. of another person	Yes ☐	No ☐
Exposure to radiation or radioactive contamination	Yes ☐	No ☐

If you have answered yes to any of the above causes, please give details on page 6.

What diagnosis have you been given for the condition causing your incapacity?

Please give a description of the symptoms you have been experiencing:

Please confirm the details including the dates of any appointments you have had with medical attendants or other medical professionals for your condition/symptoms:

Has your condition varied since your incapacity commenced?

Yes ☐ No ☐ (tick as appropriate)

(If yes, please explain how it has varied)

Which of the following best describes the progression of your condition? (Please tick the appropriate box)

Improving ☐ Static/Not improving ☐ Deteriorating ☐

3.1 Condition History

Have you previously been diagnosed with this condition, and/or previously experienced these symptoms?

Yes ☐ No ☐ (tick as appropriate)

(If no, please move to 3.2. If yes, please answer the following questions)

When did you last suffer this condition?

How frequently do you experience these symptoms?

What treatments were you advised by your medical attendant to receive?

Did you receive the treatments advised?

Did you require any absence from work?
(If yes, please state for how long)

3.2 The Effects of your Condition

3.2.1 Occupational Incapacity

If immediately prior to the start of your incapacity you were normally and regularly following an occupation for profit or reward, please complete this section. If not, please complete section 3.2.2.

Please state the first date you were absent from work as a result of your condition:

Have you been unable to work since the first day of your incapacity? (If yes, please state those dates)

Yes ☐ No ☐ (tick as appropriate)

Have you now returned to work?
(If yes, please state the date you returned to work)

Yes ☐ No ☐ (tick as appropriate)

If you have not returned to work, please estimate how long before you anticipate being able to return to work.

(Tick the box most appropriate)

☐ Less than 2 weeks
☐ Between 2 weeks and 1 month
☐ Between 1 month and 3 months
☐ Between 3 months and 12 months
☐ More than 12 months
☐ Never

Please describe all the essential duties of your occupation:
(A duty is an 'essential duty' if it is a significant part of your occupation. For instance, dispensing prescriptions would be a key duty of a community pharmacist.)

Please describe how your condition totally prevents you from undertaking all the essential duties of your occupation:

Do you have more than one occupation?

Yes ☐ No ☐ (tick as appropriate)

(If yes, please give details of the essential duties of this occupation, whether you follow it part-time or full-time, and how your condition prevents you from continuing the essential duties of this occupation.)

3.2.2 Disability Incapacity

If you were not normally and regularly following an occupation prior to the start of your incapacity, please complete this section.

As a result of your condition, are you necessarily permanently confined to your normal place of residence, a hospital, or other medical establishment?

(Please give details, including the date from when your permanent confinement began, and why.)

Are you totally unable to perform any of the following activities unaided?

Dressing and undressing	Yes ☐	No ☐
Washing and bathing	Yes ☐	No ☐
Eating and drinking	Yes ☐	No ☐
Preparing and cooking food	Yes ☐	No ☐
General household duties such as cleaning and laundering clothes	Yes ☐	No ☐
Climbing stairs	Yes ☐	No ☐
Shopping	Yes ☐	No ☐

(If yes, please give details, including the date from when you could not perform the activities concerned, why you cannot perform them and what aid you receive.)

4. Other Material Information

Do you permanently reside outside the United Kingdom?

Yes ☐ No ☐ (tick as appropriate)

If yes, please give details.

Do you undertake any work for profit or reward outside the United Kingdom?

Yes ☐ No ☐ (tick as appropriate)

If yes, please give details.

Have you been on holiday or annual leave, or have you left the United Kingdom, since the commencement of your incapacity?

Yes ☐ No ☐ (tick as appropriate)

If yes, please give details.

Please give the name, address and contact telephone number of your General Practitioner.

Name:

Address:

Postcode:

Telephone number:

Please give the name and specialty of any other medical attendant you have consulted with regards to your condition.

Are you related to any of the medical attendants who are, or have, treated you with regards to your condition?

If yes, please give details.

Please state here any further information that you believe is material to your claim (something is 'material' in this context if it could influence the Society's assessment of your claim).

Declaration

Please **insert your name** where required, **tick the boxes** to acknowledge your understanding of the responsibilities listed below, and **sign** and **date** the declaration.

Please note: Ensure you have completed all necessary fields in **BLOCK CAPITALS** and in **blue** or **black** ink.

Incomplete/illegible forms may lead to your claim being delayed or possibly declined.

☐ I, _____ hereby declare that I am the person referred to in the above particulars; that I have read over my replies to all the questions; and that to the best of my knowledge and belief the information given above or provided separately is true and complete.

☐ I understand that my eligibility for Income Benefit is subject to my being 'incapacitated' in accordance with the terms and conditions of my Income Protection Policy, and that I must continue to be incapacitated for the duration of any period for which I seek payment of Income Benefit from PG Mutual.

☐ I understand that my eligibility for Income Benefit is subject to my providing appropriate supporting evidence of my incapacity at such intervals as PG Mutual requests. I also give permission for PG Mutual to seek information from time to time from third parties, including but not limited to my employer, insofar as the information requested concerns my claim for Income Benefit; my compliance with the terms and conditions of my policy in respect of claiming Income Benefit; and/or the verification of information provided to PG Mutual as part of my claim for Income Benefit.

☐ I understand that if there is any material change in my condition or circumstances, I will inform PG Mutual as soon as possible.

☐ I understand that I must refrain from behaviour that may impair my recovery; that I must comply with the advice or counsel of any qualified medical adviser entrusted with my care; and I am not to unreasonably refuse to undergo any treatment or surgery recommended by any such medical adviser.

☐ I understand that I must inform PG Mutual of any work I undertake for profit or reward during any period for which I am claiming payment of Income Protection Benefit from PG Mutual, and that I must inform PG Mutual immediately when I return to work, whether full-time or part-time.

☐ I understand that if I fail to comply with my responsibilities described above, or if I fail to comply with the requirements and my responsibilities under my Income Protection Policy terms and conditions, my eligibility for Income Protection Benefit may cease and I may be liable to reimburse PG Mutual, with interest, for any benefit that I receive to which I am not entitled.

☐ I understand that the Board of Directors of the Society, if satisfied on the evidence available that I have made an improper, false or fraudulent claim for Income Protection Benefit, can at its discretion expel me from the Society and require reimbursement, with interest, of any Income Protection Benefit paid to which I am not entitled to.

Signature _____

Date _____ / / _____

Access to Medical Records Declaration

Please note: Ensure you have completed all necessary fields in **BLOCK CAPITALS** and in **blue** or **black** ink and also that you have **SIGNED** and **DATED** the form.

Incomplete/illegible forms may lead to your claim being delayed or possibly declined.

Your rights under the access to Medical Reports Act 1988

(The Access to Personal Files and Medical Reports (NI) Order 1991)

It may be necessary for us to apply for a medical report/sight of your medical records from a doctor who has cared for you, but before we can do this we need your consent, by signing the declaration below. Under the Access to Medical Reports Act 1988 (The Access to Personal Files and Medical Reports (NI) Order 1991) you have certain rights relating to any report prepared by him and these are summarised below:

1. **You do not have to give your consent. However, if you do not, this may result in us being unable to process your application/claim.**
2. **Your doctor is required to retain a copy of the medical records/medical report for at least 6 months. During this time you may ask your doctor to see a copy of this report.**
3. **If, before the medical records/report is sent to us you write to your doctor saying that you wish to see the records/ report, you then have 21 days in which to contact him to arrange access. We will notify you at the same time we write to your doctor to tell him you wish to see the medical records/ medical report.**
4. **If you wish to see the medical records/report before it is sent to us, the doctor cannot submit it until he has your consent.**
5. **You may ask the doctor to amend any part of the medical records/report which you consider incorrect or misleading. If your doctor is not in agreement, you may append your comments to the report.**
6. **The doctor can withhold access to any part of the medical records/ report if he feels you or others would be harmed by seeing it. In such cases, he must notify you and you will be limited to seeing only the remaining part of the report. If the whole medical record/report is affected, he must not submit it unless you give your consent.**

Whether or not you complete the declaration below, upon request to your doctor you have the right to see a copy of the medical records/ report up to six months after it has been submitted. However if you are provided with a copy the doctor can charge a reasonable fee to cover his costs. You should be aware that if you indicate that you wish to have access to any copy of medical records/ medical report it may result in a delay of processing your application or claim.

I have read the notes above and am aware of my rights under the Access to Medical Reports Act 1988 (The Access to Personal Files and Medical Reports (NI) Order 1991) and that:

I *do not/*do wish to see a copy of the medical records/ report and or sight of my medical records that my medical practitioner may provide before it is submitted (*DELETE AS APPROPRIATE).

Declaration

I hereby consent to the request for a medical report and or sight of my medical records relating to me by PG Mutual and authorise the release to and use by of any information required by them in connection with this application OR as a result of the sickness or/and injury which is subject to a claim.

Signature: _____

Date: _____

IMPORTANT: Please ensure you complete the **Claim Payment Authorisation Form** overleaf.

Income Protection Plan

Claim Payment Authorisation

Please note: Ensure you have completed all necessary fields in **BLOCK CAPITALS** and in **blue** or **black** ink and also that you have **SIGNED** and **DATED** the form.

Incomplete/illegible forms may lead to your claim being delayed or possibly declined.

Please quote your PG Mutual Membership Number

_____

I _____ (please print name) authorise PG Mutual to make sickness benefit payments due to me, directly into my bank account as shown below.

I understand that this authorisation will remain on file until income benefit payments are no longer payable to me under the claim because:

a) I recover from my incapacity and return to work; or

b) I reach the age of 65; or

c) in the event of my death; or

d) any other reason that is covered by the rules of the Society.

I also understand that this authorisation may be cancelled by either party by giving 14 days' notice in writing. I will give any amendments to my banking details to PG Mutual in writing as soon as possible.

In the event that a payment is made to me by PG Mutual for an incorrect amount, I agree to refund PG Mutual immediately upon receipt of the Society's written notification of any such error.

Signature: _____

Date: ____ / ____ / _____

Bank Details

Bank/building society:

_____

Address: _____

_____

Postcode: _____

Name(s) of account holder(s):

_____

_____

_____

Branch sort code:
(from the top right-hand corner of your cheque)

☐☐ ☐☐ ☐☐

Bank or building society account number:

☐☐☐☐☐☐☐☐

Signature(s): _____

Date: ____ / ____ / _____

Please note: You must provide personal account details that are in your name. We cannot accept bank details with a company title.

It is your responsibility to provide the correct account details; the Society will not accept any liability for an act or omission resulting from incorrect details being given.

Tel: **01727 840095** Fax: **01727 832710** Email: **info@pgmutual.co.uk**

PG Mutual is the trading name of Pharmaceutical and General Provident Society Ltd. Registered office: 11 Parkway, Porters Wood, St Albans, Hertfordshire AL3 6PA. Incorporated in the United Kingdom under the Friendly Societies Act 1992, Registered Number 462F. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority, Firm Reference Number 110023.

August 2018 INCOME PROTECTION PLUS - INCOME BENEFIT CLAIM FORM

pg mutual income protection plus