Coastal Marine Services Limited

Claim Form - Crew Accident / Injury

Please find below the claim form which **we require both the Assured and the injured party to complete.** Please return this to us as soon as possible with a full description of the claim incident and any supporting evidence as to the cause of the accident. You should include any receipts or invoices for which you will be seeking reimbursement. Please note that you should not commit insurers to any expenditure without their prior approval.

Failure to complete this form correctly may delay your claim

CLAIM DETAIL – TO BE COMPLETED BY THE CLAIMANT

VESSEL DETAIL

Vessel Name:	
Type of Vessel:	

INJURED PERSON

Name:	
Address:	
Date of Birth:	
Telephone Number:	
Nationality:	
Nature of Injury:	

NATURE OF ACCIDENT:

Date of Accident	
Location	
Describe in full the circumstances leading to your accident/the cause of your illness: (Please include dates and times.)	
Describe in full your injuries/illness sustained:	
On what date did you first seek medical attention:	
On what date did you stop performing ALL parts of your occupation:	
Have you engaged in ANY work since your disability began	
Date you expect to return to work is:	
If necessary, for what period were you confined to hospital:	Admitted: Discharged:

PLEASE GIVE NAMES AND ADDRESS OF EVERY DOCTOR CONSULTED FOR THE PRESENT INJURY/ILLNESS:

GP Name: Address & Postcode: Tel No:	
Consulting Doctors Name: Address & Postcode: Tel No:	
Consulting Doctors Name: Address & Postcode: Tel No:	

DOCTORS STATEMENT – TO BE COMPLETED BY ATTENDING DOCTOR

DETAILS OF THE INJURY:

Date patient seen:	
How did the accident occur:	
Injuries sustained:	
Were any dislocations sustained:	Yes / No
Did the dislocation require reduction under anaesthesia:	Yes / No
Were any fractures sustained:	Yes / No
If yes, please confirm site of fracture(s)	
Is the claimants disability solely accident/illness:	Yes / No

OR DETAILS OF THE ILLNESS:

Date of illness:	
What symptoms were displayed:	
When did they appear:	
What treatment / medication did you prescribe:	
What was your diagnosis:	

DOCTORS STATEMENT CONT...

Was an operation performed:	Yes / No
If yes, please give full details including dates:	
Is there any indication that alcohol was a contributory factor:	Yes / No
For what period was the patient confined to hospital:	Admitted: Discharged:
If the patient has not returned to work, when is the likeliest date for them to be able to resume full/part-time employment:	
For what period was the patient unable to perform any part of their occupation:	From: To:
Has the patient previously suffered from this type of injury/illness:	
If yes, please give full details including dates:	
Is the patient suffering from any other medical condition/ disability which may affect their recovery:	Yes / No
If yes, please give full details including dates:	
Is the patient:	Recovered Improved Unimproved Retrogressed
In your opinion, is the accident/ illness TOTALLY preventing the patient from working:	Yes / No
In your opinion, do you think that the patient will be left with a permanent disability solely as a result of this accident/illness:	Yes / No
If yes, please give full details of treatment, medication and consultant referrals:	

DOCTORS DECLARATION

I hereby certify that the answers I have given to the questions on this form are correct and true to the best of my knowledge and belief.

Signature .....

Print Name .....

Date .....

ACCESS TO MEDICAL REPORTS ACT, 1988/Access to Personal Files and Medical Reports (Northern Ireland) Order 1991/Access to Health Records and Reports Act 1993 (Isle of Man) (The Acts") To enable CMS to assess your claim, it may be necessary to obtain medical evidence. Any reports which are requested from your doctors are subject to the Acts. (Please note that Reports requested from Doctors appointed by CMS are not subject to the Acts).
In summary your statutory rights are as follows:

1. A Medical Report cannot be requested from any Doctor who has attended you without your written authority.
2. You do not have to give your consent. If you do consent, you can say whether you wish to see the report before it is supplied. If you do not give your consent we may not be able to proceed with your claim.
3. If you say you wish to see the report, we will write to your Doctor and tell them, and advise you that we have done so. You will then have 21 days from the date of notification to contact the Doctor to make arrangements for you for you to see the report.
4. The Medical Practitioner will be informed that you wish to have access to the report and will allow 21 days from the date of the notification for you to see and approve it before it is supplied to us. If the Medical Practitioner has not heard from you in writing within 21 days of the application of the report being made, he/she will assume that you do not wish to see the report and that you consent to it being supplied.
5. If you say that you do not wish to see the report, we do not have to notify you if we apply for one.
6. Whether or not you say you wish to see the report before it is sent to us, you may ask your Doctor to show you a copy of the report for up to 6 months after it is supplied. The Practitioner may charge you a fee for the cost of supplying a report.
7. If you see a report before it is sent to us, the Doctor cannot submit it until you give your consent. You can write to th e Doctor, asking that any part of the report which you consider to be incorrect or misleading to be amended and to have attached to the report a statement of your views on any part where you and the Doctor are not in agreement.
8. The Doctor is not obliged to let you see any part of the report if,
   a) In his or her opinion it would be likely to cause serious harm to your physical or mental heath, or that of other.
   b) It would indicate the Doctors intention towards you
   c) Disclosure would be likely to reveal information relating to, or the identity of, someone else that has supplied information about you, unless that person has consented.

DELARATION – This must be read and signed by the person making the claim

I hereby authorize any physician or any other person who has attended or examined me to furnish CMS or its authorized representatives with any and all information with respect to any illness, sickness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records.

I do / I do not (delete as necessary) wish to see a copy of the medical report before it is sent to CMS
A photocopy of this authorisation will be considered as effective and valid as the original.

I declare that the statements on this or any related form and document are true and correct to the best of my knowledge and belief and have not knowingly withheld any information connected with this claim. I agree to provide the Insurer with any further information as may be reasonably required and understand the insurer does not admit liability by issue of this or any related form.

Signature ..... Date .....

Print Name .....

CLAIM DETAIL – TO BE COMPLETED BY THE ASSURED

Name of Policy Holder:	
Address:	
Tel Number:	
Mobile Number:	
Email Address:	
Nature of Business:	

VESSEL DETAIL:

Vessel Name:	
Type of Vessel:	

INJURED PERSON:

Name:	
Address:	
Date of Birth:	
Telephone Number:	
Nationality:	
Nature of Injury:	

STATEMENT

THIS SECTION MUST BE COMPLETED BY THE ASSURED/SKIPPER/WITNESS
Please describe in full the circumstances of the accident/illness. Include dates, times and location of the incident. (Use a separate sheet if necessary)

DELARATION

In completing and signing this document I am formally registering a claim for the above damage and agree to abide by the Coastal Policy in all matters relating to this claim.
I hereby declare that the particulars and answers given in this statement are in every respect true and correct and that I have not withheld any information which may influence the decision of the Underwriters in regard to this claim.

Signature ..... Date .....

Print Name .....