

**POLICE FEDERATION**  
**PERSONAL ACCIDENT SCHEME**

**NOTICE OF ACCIDENT CLAIM IMPORTANT - PLEASE NOTE THE FOLLOWING:-**

1. To comply with the Policy Conditions, all accidents that could lead to a claim must be intimated within 90 days of the accident
2. When completing this form, if possible, you should insert both the starting and finishing date of your claim in Section A. If you are still injured, complete and return Section A where appropriate - Section B should be completed and returned when you resume your duties.
3. Payment will be made on completion of the full period of disability. If the claim is likely to be of a long duration, then you may wish to apply for an interim settlement and this should be done in writing to the Joint Branch Board's Secretary at the Federation Office.
4. The issue of the claim form is in no way an admission of liability
5. Whilst medical evidence is not normally required in support of a claim, the insurance company reserve the right to require an applicant to supply a medical certificate without expense to the company.

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**SECTION B**

**On completion of Section A on page 3, retain this portion if you are still unable to resume your duties.**

**Name of Force:** \_\_\_\_\_ **Claim No:** \_\_\_\_\_

**Division:** \_\_\_\_\_ **Rank:** \_\_\_\_\_ **No:** \_\_\_\_\_

**Name of member:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_  
**Postcode:** \_\_\_\_\_

**Telephone No:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Claimants Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**I refer to claim previously intimated and wish to advise you of my final return to full / part time duties on: -** \_\_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**BANK DETAILS**

When your claim has been approved we will make the payment to you directly to your Bank Account by BACS transfer.

Please complete the following: -

Name and address of your Bank:

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Branch Sort Code: \_\_\_\_/\_\_\_\_/\_\_\_\_

Account Number: \_\_\_\_\_

Account Name(s): \_\_\_\_\_

**SECTION A (NOTE: COVER IS FOR ACCIDENTS ONLY)**

**CLAIM FORM - Complete this section and retain Section B**

**Serving**

**Police Staff**

**Name of Force:** \_\_\_\_\_ **Claim No:** \_\_\_\_\_

**Name of member:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_ **Postcode:** \_\_\_\_\_

**Email address:** \_\_\_\_\_ **Mobile Telephone No:** \_\_\_\_\_

**Claimants Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Date of accident:** \_\_\_\_\_

**I have been absent from duty for the following period:** \_\_\_\_\_ **days**

**Date absence commenced:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Last date of absence:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Date returned to work:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Exact nature of injuries:** \_\_\_\_\_

**Exact nature of accident which caused these injuries:** (It is necessary to show the injuries resulted from an unexpected and unusual event)

\_\_\_\_\_  
\_\_\_\_\_

**On Duty\* / Off Duty\* (\*delete as appropriate)**

**Have you sustained injuries of this nature previously?** **Yes / No**

**If yes, please give details:** \_\_\_\_\_

\_\_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

**To be completed by the Trustees of the Federation Insurance Scheme.**

**I certify that the beneficiary is a subscribing member of the scheme and is entitled to cover provided under it.**

**Signed:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Date:** \_\_\_\_\_