Cooper Gay

CLAIM FORM

Swimrun-Athletes-Insurance Program

In case of any medical emergency, please directly contact the 24-hour emergency hotline (MOS medical helpline) +49 (0)69/ 9 77 88 99-999

In case of any other claims request, please contact the hotline of our claims handling office Sedgwick TPA via +49 (0) 211 / 5401 4210 or send an email to swimrun@de.sedgwick.com

STEP 1 – CLAIM FORM COMPLETION REQUIREMENTS

- Please use block letters.
- Please read this claim form and complete all required details asked for in this form.
- Documents in a foreign language are required to be translated into English at your own expense.
- The claim form and all supporting documentation may be posted or e-mailed.
- Please provide us with original documents only.
- Please refer to the specified documentation requirements that you will need to provide when lodging your claim. As each is unique, further information may be requested by us.
- Supply a copy of your certificate of insurance and a confirmation of race participation.
- If any part of your claim is of a dishonest or fraudulent nature, your claim will be denied and referred to the relevant authorities.
- This claim form should be completed and returned with supporting documentation to swimrun@de.sedgwick.com or to the following address:

Sedgwick Germany GmbH

Gladbecker Straße 1, 40472 Düsseldorf

+49 (0) 211 / 5401 4210

Please choose the applicable box(es) below relating to your claim and answer the corresponding Section.

☐ **A.** Personal Accident Insurance

☐ **B.** Personal Liability Insurane (subsidiarily applicable only)

☐ **C.** Travel and Curtailment Insurance

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STEP 2 – CLAIMANT DETAILS

1. Name of insured person: ____
2. Date of birth: ____
3. Address: ____
4. Contact details (phone no., e-mail): ______________________________________
5. Registration No.: ____
6. Have you made previous accident, liability or travel insurance claims? □ YES □ NO

   If yes, please complete the table below:

Date of Claim	Name of Insurer	Claim Number	Details of Claim	Amount Paid

7. Is this claim covered by any other insurance policy (i. e. through your employer, credit card provider, associations etc.)? □ NO □ YES ; If yes, please fill in the following table.

Name of insurer	Type of insurance (accident, liability or travel insurance)	Policy no.	Claim no.	Contact / phone no.

STEP 3 – CLAIM INFORMATION

In this section we will ask for the circumstances of your claim and the amount that you are claiming.

General Claim Information:

1. Date of loss: ____________________
2. Location and country of loss: ______________________________________
3. Circumstances of loss (Please provide a detailed description of what happened and where. Use an additional sheet, if necessary.):

____

____

____

4. Estimated total amount of costs: ____________________________________

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STEP 3 – A. Personal Accident Insurance

1. What where the consequences of the accident (diagnosis / type and extent of the injuries)?
   ____

2. Did you consume alcohol/ drugs/ medication within the last 24 hours prior to the accident?
   □ NO   □ YES (Please state what type, the amount and within which time period)
   ____

3. When did the medical treatment/care start? (date/time):
   ____

4. Please give name and address of the medical attendant (doctor/hospital):
   ____

5. Please submit any medical report available. In case you have been treated in a hospital, please submit the hospital report.

6. Did you suffer from any illness or other health issues before this accident? (i.e. epilepsy, Parkinson, fainting, cramping, dizziness, stroke, hypertonia, diabetes, nerve damage, vision or audio limitations) □ NO   □ YES (Which?) ______________________________

7. Have you had accidents before, which led to an injury? □ NO   □ YES (When? Which type of injury?) ______________________________

STEP 3 – B. Personal Liability Insurance

If anyone is holding you responsible for their claim, insist their claim must be in writing. **Do not admit liability.**

Are there witnesses of the incident or did the Police record the incident?

□ NO   □ YES ; Name(s) and address(es) of witness(es): ______________________________

____

Police record / journal no. ______________________________

Address of Police Station ______________________________

Please give us the following details about the Third Party involved:

1. Name of third party: ______________________________

2. Date of birth / age: ______________________________

3. Address: ______________________________

4. Contact details (phone no., e-mail): ______________________________

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STEP 3 – C. Travel and Curtailment Insurance

1. Please provide us with the following documents / information:

- your travel itinerary and cancellation documents (available from your travel agent)
- your receipt from the travel provider showing the full cost of the travel tickets or minimum prepaid travel expenses
- a list of total costs claimed
- documentation and confirmation/receipt of paid entry/participation fee
- any medical documentation in case of any medical reason (i.e. serious accident / unexpected serious illness or pregnancy etc.)

2. On what date did you amend/cancel the trip? ____

3. Reason(s) for trip amendment /cancellation: ____

STEP 4 – PAYMENT DETAILS

To whom should any payment be made? ____

For Electronic Fund Transfer, please provide your full bank details; Bank Name, Bank Address, Account No, Sort Code, Swift Code & IBAN and Name of Account Holder:

____

____

____

PERSONAL OR SENSITIVE INFORMATION – ACCESS TO MEDICAL REPORTS (a signed authorisation must be completed by the sick/injured person)

As part of your claim a medical report and/or medical notes may be required from your doctor. However, before we can apply for a medical report / notes your consent is needed. Before signing the consent to obtain medical information at the end of this form, you should know that you have the following rights:

1. You can withhold your consent, but if you should do so we may be unable to process your claim.
2. If you wish to see the report we will tell you at the same time that we write to the doctor and you will then have 21 days to contact the doctor about arrangements for you to see the report /notes. Whether or not you wish to see the report / notes before they are sent to us, the doctor must let you see a copy for up to six (6) months after it is supplied to us, if you ask for it.
3. You can ask your doctor to amend any part of the report / notes, which you consider wrong or misleading. If the doctor will not agree to this, you may add your own comments.
4. Your doctor can, in certain circumstances, withhold from you the report / notes or any part of it.

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Consent to Obtain Medical Report / Medical Notes

I have read the statutory rights above, under the Access to Medical Reports Act 1988 and I hereby agree to Tokio Marine Kiln Group Ltd as well as Sedgwick TPA on behalf of Tokio Marine Kiln Group Ltd seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health in connection with this claim.

☐ I wish to see the report / notes before they are sent to Tokio Marine Kiln Group Ltd or Sedgwick TPA on behalf of Tokio Marine Kiln Group Ltd *(tick as required)*

Full Name of Insured or Authorised Person: ____

____

Date | Signature (If insured person is a minor, please provide signature of parent or legal guardian)

Declarations

☐ I declare that to the best of my knowledge, the particulars presented herein are true. I understand that any person who knowingly and with intent to defraud or deceive any insurance company, files a claim containing any materially false, incomplete or misleading information, may be subject to prosecution for insurance fraud. I also understand and consent that information herein may be made available to other insurers for underwriting and claims handling purposes and consent to Tokio Marine Kiln Ltd as well as Sedgwick TPA on behalf of Tokio Marine Kiln Group Ltd seeking information from other insurers to confirm any information presented.

Full Name of Insured or Authorised Person: ____

____

Place / Date | Signature (If insured person is a minor, please provide signature of parent or legal guardian)

MEDICAL CERTIFICATE

regarding illness/ accident/ unexpected vaccination intolerance or prophylaxis intolerance of the insured or risk person – to be completed and signed by the attending physician

Patient's name: ____ Date of birth: ________________________

Patient's address: ____

1. Diagnose(s)

Diagnose(s) including ICD-Code, which led to the trip cancellation

____

____

____

Date of first notice of this diagnose(s) or date of accident: __________________________________

When did the patient first see a doctor about his / her symptoms? (Date) ___________________

1.1 Pregnancy

When was the pregnancy ascertained and in which week of the pregnancy? ______________

When was it first apparent that the journey / event could not be reasonably undertaken in view of the pregnancy? (Date) ____

Have there been any complications? □ NO □ YES (Which?) _______________________________

____

Has there been any inpatient treatment or is it scheduled or recommended?

□ NO □ YES (When?) ____

2. Incapacity for work

Has there been any incapacity for work due to the illness/accident?

□ YES, from ______________ until ____________________

□ NO (reason(s), why not:) ____

3. Inpatient Treatment

Has there been inpatient treatment ? □ NO □ YES, from _______________ until ______________

If YES, please provide us with a medical report from the treating hospital attached to this Medical Certificate!

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4. Therapeutic measures and medications
Which therapeutic measures have been taken and what was the medication?

____

____

What are the treatment dates related to this illness? (Please give single dates.)

____

Has the patient been referred to a specialist? □ NO □ YES, on (Date) ____________________

Name and address of the specialist: ____

____

____

5. Progress of illness / medical history
Did the illness occur a longer time ago? □ NO □ YES, since (Date) ______________________

Have there been or are there illnesses, which are or might be associated with the current diagnose(s)?

□ NO □ YES, since ____________________

Diagnose: ____ ICD Code: ____________

What are the treatment dates to this (pre-)existing illness within the last two years?

____

When did the (pre-)existing illness worsen? Since (Date) _________________________________

6. Travel Reservations
Have you been asked whether the patient is fit to travel prior to the travel booking?

□ NO □ YES, first on (Date) ________________________

Has the patient been fit to travel at the time of booking? □ NO □ LIMITED □ YES

When was it obvious that –from a doctor's perspective- due to health reasons the booked journey / event was no longer possible? (Date) ____

When did you as the attending physician advise the patient against the journey?

(Date) ____________________

In case, the date when you advised against the journey, would be different to the date of first notice of the current diagnose(s), please advise us of the reasons why:

____

____

____	___________________________________
Place / date and signature of attending physician	**Practice stamp of attending physician**