DISABILITY REPORTING FORM FOR LOSS OF LICENCE

INSURANCE

PART 1 - INSTRUCTIONS AND UNDERTAKINGS:

Please read the following notes carefully before completing this form.

BACKGROUND:

Flight Crew are employed in different countries and some difficulties have been encountered by the Insurer in obtaining the information necessary to determine whether there is a valid claim under the policy. If information is not provided in a prompt and efficient manner, it will slow down the Insurers ability to reach a decision on your claim or in extreme cases may invalidate it.

As national practice varies, the following notes are provided to assist you in understanding what the Insurer requires of you, what you need to do and when you need to do it.

The policy provides a disability benefit if You become Disabled during the Period of Insurance as a consequence of Bodily Injury or Illness and the Disablement continues for longer than the Waiting Period shown in the Schedule. The Insurer will pay the Disability Benefit for each subsequent month for which the You remain Disabled.

There is a referee procedure specified in the policy if you disagree with the Insurers decision and this is based solely on medical grounds.

REPORTING A SICKNESS OR DISABILITY:

To comply with the terms of your insurance policy, all events that might give rise to a claim must be notified within 30 days. You must therefore report any accident or illness from which you suffer IF:

(a) You are continuously absent from work for more than 28 days; OR

(b) Your flying licence is suspended on medical grounds; OR

(c) You believe it is likely that your flying licence may be suspended on medical grounds.

Reporting an accident or illness does **NOT** mean you have to make a claim but it protects your interests if you need to do so at a later date. It will not prejudice your flying career.

To protect your interest under the policy, you must complete all sections promptly and as completely as you can. You should then return it to: Lumley Insurance Limited, Southway House, Southway, Cirencester, Gloucestershire, GL7 1FN

If you do not comply with the terms of your insurance policy your ability to claim at a later date may be delayed, reduced or lost if the Insurer is unable to complete any investigations that they are entitled to make.

COMPLETING THIS FORM:

All sections of the sickness form **MUST** be completed in full.

If you have received a temporary suspension from the Licencing Authorities, please attach a copy to your sickness form or submit a copy once received.

If you have any medical reports relating to the sickness, please provide copies of them as they may assist in expediting your claim.

If your claim is for Income Protection or a Temporary Benefit:

In addition to completing this form, you must provide evidence of your salary if your policy covers income protection. In order to do this, the Insurer will require at least 4 consecutive months wage slips to include current month.

You must also provide details of any other benefits you will receive, i.e. any company or private insurance or any social or state insurance.

You must continue to provide this evidence when requested by the Insurer from time to time during the period of disability.

YOUR RESPONSIBILITIES DURING A PERIOD OF DISABILITY:

You and your attending physicians will need to demonstrate to the Insurer that:

1) You are under the care of appropriately qualified medical professionals who are treating your health problems in a diligent and timely manner.

2) You are following a course of treatment that will, if at all possible, restore your medical certificate and enable you to return to flying duties with your employer.

3) You are attending treatment in a timely manner as and when required by your doctor/s unless you have reasonable excuse.

4) You are complying with your employer's sickness reporting procedure.

The Insurer may require detailed medical reports from your attending physicians and may require you to attend an independent medical assessment.

In most cases, provided that you are in regular contact with your employer and your attending physicians you will not need to take any further action. It is therefore in your interest to ensure that you do this.

If your physicians feel that there is a course of treatment available which could assist in restoring your medical certificate(s) but that the treatment is not appropriate in your case, it is very important that this is explained to the Insurer, with full reasons, at the earliest possible opportunity.

DATA PROTECTION ACT 1998

Catlin includes Catlin Underwriting Agencies Ltd and Catlin Insurance Company (UK) Ltd ("the Insurer")

The information provided on this form, together with medical and any other information obtained from you or from other parties about you in connection with this policy, will be used by the Insurer for the purposes of determining your application, the operation of insurance (which includes the process of underwriting, administration, claims management, rehabilitation and customer concerns handling) and fraud protection and detection.

Information will be transferred to the UK and may be transferred outside the EEA for these purposes.
Information may be shared by the Insurer for these purposes with group companies and third party insurers, reinsurers, insurance intermediaries and service providers. Such parties may become data controllers in respect of your personal data.

By completing and submitting this form, you consent to the processing of any personal data about you, including sensitive personal data, the transfer of such personal data about you overseas for these purposes as set out in this notice by the Insurer and any other data controllers to which the personal data are transferred or disclosed for these purposes.

Your personal data will be processed fairly and securely in accordance with the Data Protection Act 1998. Your personal data will only be available to those who need to see it. For example, sensitive data, such as medical records will be used for the purposes of underwriting or claim management and rehabilitation only.

You are entitled to a copy of all your personal data upon receipt of a written request to the following address: The Compliance Officer, XLCatlin, 20 Gracechurch Street, London, EC3V 0BG

PART 2 - PERSONAL INFORMATION:

1. Surname:
2. First Name(s):
3. Rank:
4. Address: (in full)

   Post Code:
5. Telephone:
6. Email:
7. Date of Birth: (dd/mm/yyyy)
8. Main Employer:
9. Date cover commenced under this policy: (dd/mm/yyyy)

10. Were you required to complete an application form to obtain this cover: Yes ☐ No ☐
11. Monthly Taxable Earned Income: (Main Employer)
12. Any other earned income:
13. Does your employer provide a sickness benefit? Yes ☐ No ☐
    If **YES**, at what rate and for how long:

    _____ per week/month (delete as applicable)

    for

    _____ week/month(s) (delete as applicable)
14. Do you have any other personal policies which provide a regular income as a result of sickness? Yes ☐ No ☐
    If **YES**, at what rate and for how long:

    _____ per week/month (delete as applicable)

    for

    _____ week/month(s) (delete as applicable)
15. During this period of sickness will you receive any other regular income? Yes ☐ No ☐
    If **YES**, at what rate and for how long:

    _____ per week/month (delete as applicable)

    for

    _____ week/month(s) (delete as applicable)

Failure to disclose relevant information may result in the non-payment of a claim and all cover under the policy being cancelled.

16. Are you eligible to claim under another Loss of Licence, Disablement or Accident Insurance policy which pays a lump sum or monthly benefit?
If **YES,** please give name of insurer(s), policy number(s) and benefit payable. Yes ☐ No ☐

17. Type of aircraft flown: (please tick all which apply)

Fixed Wing	
Rotor Wing (On Shore)	
Rotor Wing (Off Shore)	

18. All current licences at time of grounding: (Please specify type, number & country of issue)

Type	**Number**	**Country of Issue**

19. Has any limitation or waiver ever been endorsed on your medical certificate (other than the requirement to wear glasses)? Yes ☐ No ☐
If **YES,** please give dates and details then proceed to Part 3. If **NO**, proceed to Part 3:

PART 3 - TREATMENT INFORMATION:

20. Name of your Aviation Medical Examiner:

21. Name of your usual doctor/family physician:

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22. Does your usual doctor/family physician hold your full medical history notes? Yes ☐ No ☐
If **NO,** please provide the name of the Doctor(s) who does hold this information then proceed to question 23. If **YES,** proceed to question 23.

23. Have you seen any other medical professionals about your condition? Yes ☐ No ☐
If **YES**, please give full contact details and then proceed to Question 24.
If **NO**, proceed to Part 4.

24. Have you seen more than one other medical professional? Yes ☐ No ☐
If **YES**, provide the name of the last person you saw and then proceed to part 4
If **NO**, proceed to part 4

PART 4 - MEDICAL INFORMATION:

25. Was the condition discovered or diagnosed at your routine renewal examination? Yes ☐ No ☐
If **YES**, give the date of the examination and then proceed to Question 29. If **NO**, proceed to question 26. (dd/mm/yyyy)

26. Date you first had symptoms: (dd/mm/yyyy)

27. Describe these symptoms:

28. Have you ever had the same or similar symptoms before? Yes ☐ No ☐
If **YES,** please give date and contact details of the doctor or hospital that treated you then proceed to question 29. If **NO**, proceed to question 29.

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29. Were you hospitalised as a result of your sickness or injury? Yes ☐ No ☐
If **YES**, please give contact details and dates of your admission and discharge then proceed to question 33. If **NO**, proceed to question 30.

30. Who first treated you for this sickness or injury?

31. When was your first consultation? (dd/mm/yyyy)

32. Have you had any subsequent consultations? Yes ☐ No ☐
If **YES,** please give dates then proceed to question 33. If **NO**, proceed to question 33.

33. Have you received any other treatment for your sickness or injury? Yes ☐ No ☐
If **YES,** please give contact details and dates and then proceed to question 34.
If **NO**, proceed to question 34.

34. Diagnosis: (as you know it)

35. When did you stop work? (dd/mm/yyyy)

36. Did you cease work solely due to this injury or illness? Yes ☐ No ☐

37. Did you cease work on this date on medical advice? Yes ☐ No ☐

If **NO** to questions 36 or 37, please give details, then proceed to question 38. If **YES**, proceed to question 38.

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38. If the condition was not discovered at a routine renewal examination, has the condition been notified to your Aviation Medical Examiner or licensing authority? If **YES**, please give date notified. If **NO**, advise reason why. (dd/mm/yyyy) Yes ☐ No ☐

39. What is the current status of your licence(s)? Please tick which applies: (If you hold more than one licence, state the position for each)
Temporarily Suspended: ☐
Long Term Unfit ☐

Please give dates of all periods of formal invalidation of your licence/official grounding for this condition

40. If your licence is Temporarily Suspended, do you anticipate that you will regain your medical certificate? Yes ☐ No ☐

41. Have you ever been grounded or had your licence invalidated for any other condition? If **YES,** please give dates and details. Yes ☐ No ☐

PART 5 - DECLARATION:

I hereby declare:

- that I have read my answers to the questions in this sickness form and, to the best of my knowledge and belief, the answers to the foregoing questions, whether in my own handwriting or not, are true and complete.
- that I have not withheld any information which might influence the decision of the Insurer with regard to any aspect of this claim.

I understand that this information and any other medical information provided to the Insurer will be used to determine my eligibility to receive benefits under an insurance policy in respect of sickness or injury.

I understand that inaccurate or incomplete information may affect my ability to receive benefits under this policy.

Signed Dated (dd/mm/yyyy)

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NOTICE OF STATUTORY RIGHTS UNDER THE ACCESS TO MEDICAL REPORTS ACT 1988

Your Rights

- You can withhold your consent to the application of medical reports but without it, we may be unable to proceed in the assessment of your claim and this will delay any benefits or even mean no benefits can be paid at all.
- If you do give your consent you can indicate in the Declaration whether or not you wish to see the reports before the doctor sends them to us.
- If you wish to see any report we must tell you if we apply for one and notify the doctor of your wishes.
- You will have 21 days to arrange with the doctor to see the report before it is sent to us.
- You have the right to ask the doctor, in writing, to amend any part of the report which you consider incorrect or misleading and you can ask him to attach a statement of your views on any part he refused to amend.

Exemptions

- The doctor does not have to let you see any part of a report that he considers would be likely to cause serious harm to the physical or mental health of yourself or others, or that would indicate his intentions towards you. He also does not have to let you see any part that would be likely to disclose information about, or the identity of, another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional caring for you. If the doctor does not let you see any part of the report, he must notify you of that fact.

Time Limit

- Once the report has been supplied, the doctor must keep a copy of it for six months and you are entitled to inspect it or receive a copy of it during that time.

Procedures

- If you indicate in the Declaration that you do not wish to see any report, the doctor can send it to us immediately.

If at any time within the six months time limit you change your mind, you should notify the doctor that you wish to see the report and arrange with him to do so or to supply you with a copy. If you indicate in the Declaration that you do not wish to see any report we will notify you if we apply for one and you will then have 21 days to arrange with the doctor to see the report before he sends it to us. This could, of course, delay the processing of medical information. The doctor is entitled to charge you a fee for any copy report supplied to you.

If you do **not** wish to see the report before it is sent to the Insurer, please tick this box. ☐

If you **do** wish to see the report before it is sent to the Insurer, please tick this box. ☐

I consent to any medical reports, already requested and received by my employer, to be provided to my Income Protection insurer for the purposes of processing my claim. ☐

Signed _____ Dated _____
(dd/mm/yyyy)

Failure to disclose relevant information may result in the non-payment of a claim and all cover under the policy being cancelled.

TEMPORARY BENEFIT PAYMENTS

Please provide bank details for use in respect of any temporary benefit payments that become due. This information will only be used for the payment of benefits due under this policy.

Bank: .....

Sort Code: .....

Account Name: .....

Account Number: .....