INTERNATIONAL SICKNESS REPORTING FORM FOR LOSS OF COMMERCIAL FLYING 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 payment on the permanent or temporary suspension of your flying licence on medical grounds. With improvements in treatment and continual changes to aviation medicine, the Insurer will no longer automatically follow a permanent denial of your flying licence even if issued. For payment of a lump sum benefit, the Insurer must be satisfied that there is no reasonable prospect that you will return to flying duties for at least 5 years. For payment of a temporary benefit, the Insurer must be satisfied that you do not meet the minimum health standards required.

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:

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 questions promptly and as completely as you can. You should then return it to Accept Försäkringsaktiebolag, Box 2068, SE-174 02 Sundbyberg, Sweden.

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 interests 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

Accept Försäkringsaktiebolag ("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 may be transferred overseas 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 such third parties and any other data controllers to which the personal data are transferred or disclosed for these purposes.

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: Accept Försäkringsaktiebolag, Gustavslundsvägen 147, 167 51 Bromma, Sweden.

ACCEPT
Försäkringar

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/mmm/yyyy)
8. Main Employer:
9. Date cover commenced under this policy: (dd/mmm/yyyy)
10. Were you required to complete an application form to obtain this cover: Yes ☐ No ☐
11. Monthly Taxable Earned Income: (Main Employer) (ccy)
12. Any other earned income: (ccy)
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 a loss of licence, disablement or accident Insurance policy? Yes ☐ No ☐
If **YES,** please give name of insurer(s), policy number(s) and benefit payable .

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:

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

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.

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

27. Describe these symptoms: (dd/mmm/yyyy)

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.

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.

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

31. When was your first consultation? (dd/mmm/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 details (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/mmm/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.

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? (dd/mmm/yyyy) Yes ☐ No ☐

If **YES**, please give date notified. If **NO**, advise reason why

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

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

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

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

PART 5 – AUTHORISATION TO OBTAIN MEDICAL INFORMATION:

The Insurer may require detailed medical reports from your attending physicians and may require you to attend an independent medical examination. In addition to any safeguards which may apply under local laws to the Insurer or physicians in respect of such reports, the Insurer needs your consent before they can apply for a medical report from your doctor or other medical practitioner. In the event that you do not consent, the Insurer may be unable to process your claim or continue with benefits for a claim already in existence. By completing and signing the declaration section below, you consent to the Insurer applying for a medical report from your doctor or other medical practitioner and the transfer of any such report to the Insurer and/or reinsurers, who may be located outside the jurisdiction.

PART 6 - 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/mmm/yyyy)