Scottish Equestrian Insurance Services

For SEIS use

Claim Form - Personal accident

Issue of this form does not constitute admission of liability on the part of the Insurers.
The completed form should be returned to: **SEIS, PO Box 224, Huddersfield, HD8 1FS.**
CLAIMS RECEIVED THAT ARE INCOMPLETE OR MISSING INFORMATION WILL BE RETURNED TO YOU.
Information contained within this document will be made available to other insurers and organisations.
PLEASE COMPLETE IN BLOCK CAPITALS

0345 070 1063
Please phone if you have any questions regarding this form.

YOUR DETAILS (PLEASE COMPLETE IN ALL CIRCUMSTANCES)

Policy Number

Title Initial Surname

Daytime tel number

Email

Address

County Postcode

THE HORSE

Name

Type/Breed

Colour

Sex

Year of Birth

Sum Insured

Freeze Mark

ACCIDENT DETAILS

Please give details of the person injured

Name

Address

County Postcode

Date of Birth

Occupation

Date of Accident

For what purpose was the animal being used at the time the accident occurred?

Please give full details of the injuries

(Please continue on a separate sheet if necessary)

Was the injured person riding, handling or leading the horse? ☐ Yes ☐ No

How did the accident happen?

(Please continue on a separate sheet if necessary)

Was the injured person wearing an approved riding hat at the time the accident occurred? ☐ Yes ☐ No

DECLARATION

I/We consent to the seeking of information from other Equine Insurance Underwriters and Intermediaries to check the answers. I/We have provided, and I/We authorise the giving of such information for such purposes.

Signature of Policyholder(s)
✗ Date / /

Signature of the Injured Person
✗ Date / /

Fraud Warning The submission of a bogus of exaggerated claim, either in whole or in part, or any false documentation or statement in support of a claim, may invalidate the whole claim and lead to your policy being declared void.

MEDICAL/DENTAL CERTIFICATE - TO BE COMPLETED BY THE MEDICAL/DENTAL PRACTITIONER AT THE POLICYHOLDER'S EXPENSE

Injured person's name and address

Name

Address

County Postcode

Are you the injured person's usual medical/dental attendant? ☐ Yes ☐ No

If YES, for how long have they been registered with you?

When did you first attend the injured person for the injuries? / /

What did you believe to be the cause of the injury?

What is the nature and extent of the injuries sustained?

(a) Please state the area of the body affected (e.g. left/right/upper/lower/limbs/hands/feet/jaw)

(b) Will the injuries give rise to:

(i) Permanent Loss of limb, eye or hearing? ☐ Yes ☐ No

(ii) Permanent Total Disability entirely preventing the injured person from any type of work? ☐ Yes ☐ No

(iii) The hospitalisation of the injured person? ☐ Yes ☐ No

If you have answered YES to the above questions please give full details

If you have answered YES to (iii) above please give the date from which incapacity/hospitalisation commenced and ended

From / / To / /

Are there any aspects of the injured person's previous medical/dental history which may have a bearing on this claim?

Please state the total cost of the injured person's treatment or estimate if treatment not yet concluded (deleting any treatment cost unrelated to the accident) £

Has the treatment finished? ☐ Yes ☐ No

Medical/Dental Practitioner

Name

Address

County Postcode

Date / /

Professional qualifications

Signature

X

Date / /

Doctors/Dental Practice stamp (if applicable)