KBIS
BRITISH EQUESTRIAN INSURANCE

Claim Form

Having difficulty completing this form?
Get in touch and we'll help
Tel: 01635 247474 (choose equine enquiries)
Email: ask@kbis.co.uk

Personal Accident Claim Form

This form should be completed by Policyholders who intend to submit a Personal Accident claim to KBIS.

You must take care when answering the questions on this form. KBIS' claim assessor will use the information provided within this form to decide whether a claim should be accepted. If you do not understand the questions or the nature of the information required please contact KBIS. Failure to provide information or the provision of incomplete or inaccurate information may affect this claim.

There are conditions, limitations and excesses within the terms and conditions which may prevent KBIS paying for everything you claim.

Policyholder's Details

Reference No: ……

Title: ……

Forename(s): ……

Surname: ……

Address: ……

……

……

Mobile number: ……

Email address: ……

Documents you will be sending to KBIS.

Please indicate below which documents have been enclosed with this form:

Items marked with an asterisk must be supplied unless KBIS have agreed otherwise

Death Certificate ☐
Medical Report(s) ☐
Grant of Probate ☐
Dental Invoices & Report ☐

Return your form to KBIS Limited, Cullimore House, Peasmore, Newbury, Berkshire, RG20 7JN

About the Accident

This section should be completed by the policyholder. If the injured party is not the policyholder they should also complete relevant questions that form part of this section.

Is the party involved in the accident the person named as the policyholder? Yes ☐ No ☐

If no, please give the person's name:

Please provide their date of birth

Please provide their occupation

If the injured party is not the policyholder please explain their relationship to the policyholder

Please provide their address:

Please provide their telephone number:

On which date did the accident occur:

Was the person riding, handling or leading the horse at the time of the accident? Riding ☐ Handling ☐ Leading ☐

How did the accident occur?
(Tell us what activity the person was undertaking and what caused the accident)

Please detail the injuries sustained:
(Continue on a separate sheet if necessary)

Was the injured person wearing a BSI/European Standards approved hat at the time of the accident? Yes ☐ No ☐

Please confirm the standard number:

Return your form to KBIS Limited, Cullimore House, Peasmore, Newbury, Berkshire, RG20 7JN

Details of the Claim and Claim Declaration

Which benefit do you intend to claim upon?

(Please tick all that apply)

Death ☐

Permanent Total Disability ☐

Loss of Limb ☐

Loss of sight in one or both eyes ☐

Deafness in both ears ☐

Dental Work ☐

If your claim relates to dental work please state the amount you are claiming:

Should the claim payment be made to the policyholder or somebody else?

The Policyholder ☐ Somebody else ☐

If you'd like us to pay someone else please state to whom payment should be addressed:

Declaration

- I declare that all the statements contained within this form are correct to the best of my knowledge.
- I understand that if I have witheld information or misrepresented the facts upon which I have based this claim that my claim may not be paid and that the Insurer may void my policy.
- I give permission for KBIS and/or the Insurer to access my medical records.
- I understand that KBIS and/or the Insurer may appoint their own medical expert to assess this claim, I agree to cooperate with their medical representatives if necessary.

Signature:

Date

Return your form to KBIS Limited, Cullimore House, Peasmore, Newbury, Berkshire, RG20 7JN

Medical/Dental Certificate

This section should be completed by the medical/dental practitioner.

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

When did you first attend the injured person for this accident?

Are the injuries observed commensurate with the accident? Yes ☐ No ☐

Please describe the nature and extent of the injuries sustained.

Please state within this description the location of the injuries.

Will the injury(s) give rise to any of the following?

Permanent Total Disability ☐

Loss of Limb ☐

Loss of sight in one or both eyes ☐

Deafness in both ears ☐

Is there any previous medical/dental history which may have a bearing on this claim? Yes ☐ No ☐

If yes, please describe the conditions and the effect they have had:

If applicable, please state the total cost of the injured person's treatment:

Has treatment concluded? Yes ☐ No ☐

Please provide your name:

Practice Address:

Signature and Practice Stamp

Date:

Return your form to KBIS Limited, Cullimore House, Peasmore, Newbury, Berkshire, RG20 7JN