



<b>Please confirm the nature of the injuries you sustained:</b>	
<b>Have you ever had this injury, or similar injury, in the past:</b>	
<b>If yes, when &amp; please provide full details:</b>	
<b>When did you first consult a Doctor?</b>	
<b>Name &amp; address of Doctor consulted:</b>	
<b>Name &amp; address of your usual family Doctor:</b>	
<b>Please provide names and addresses of any witnesses.</b>	

**If claiming Dental or Optical treatment:**

Please provide written confirmation from a qualified dentist or optician that the injury is as a direct result of the incident described above, along with original receipts for treatment

**If claiming Hospitalisation:**

<b>Date admitted to hospital (please provide copy admissions form)</b>	
<b>Name and address of hospital attended:</b>	
<b>Date discharged (please provide copy discharge form):</b>	

**If claiming Loss of Shooting Event Fees:**

Please provide evidence of your pre event registration and evidence that entry fees having been paid to the organiser and written confirmation that they are non-refundable

<b>Name, address and date of the event which you were unable to attend</b>	
<b>The date when you entered the event .</b>	

**Where applicable, claims cannot be settled until all treatment relating to the injury has been completed.**

**It is necessary that great care should be taken in the completion of this form and the information you give should be strictly accurate irrespective of whether it is in your favour.**

**Persons found to have lodged a fraudulent claim are liable for prosecution.**

The issue and acceptance of this form does not constitute an admission of liability by Underwriters.

I/We declare that the above statement and facts are to the best of my/our knowledge true, and that I/We have not withheld from the Company any information within my/our knowledge connected with this claim.

Signature of Claimant:		Date:	
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Forward to: Woodgate & Clark Ltd  
42 Kings Hill Avenue, Kings Hill,  
West Malling Kent ME19 4AJ

**WE MUST RECEIVE THE COMPLETED CLAIM FORM WITHIN 28 DAYS OF THE EVENT**

Failure to do so may prejudice your claim

## Consent for Release of Medical Records

OUR REF: SS/HZ/50-	
<b>Full Name (including any former name):</b>	
<b>Date of Birth:</b>	
<b>Date of Accident:</b>	
<b>Address and Postcode (including former address if changed since accident)</b>	
<b>Contact Telephone Numbers:</b>	<b>Home:</b>
	<b>Work:</b>
<b>Hospitals Attended (if known please give Record Number on appointment card and name of Consultant attending):</b>	
<b>General Practitioners Name and Full Postal Address:</b>	

- I consent to the disclosure of my complete Medical Records, X-rays and other scans to: **Woodgate & Clark Ltd, 42 Kings Hill Avenue, Kings Hill, West Malling Kent ME19 4AJ, and any medical adviser instructed on their behalf.**
  
- I confirm that no litigation against the medical providers, their Servants or Agents is intended.

Signed:		Date:	
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This request is in accordance with the General Data Protection Regulation 2018. We confirm that we are prepared to meet the access fee of £10.00, together with the appropriate photocopying and postal charges pursuant to this Act.

**Forward to: Woodgate & Clark Ltd, 42 Kings Hill Avenue, Kings Hill, West Malling Kent ME19 4AJ**