Independent schools

Pupil absence insurance claim form



Please refer to your Statement of Insurance for confirmation of your Franchise period, this means the number of consecutive days which must be exceeded before a claim can be considered under this Group Policy. The full period of absence will be covered, and this should not be seen as an excess.

Claims for reimbursement of school fees must be submitted as soon as the pupil is certified fit and returns to the school. Claims for individual terms should be submitted separately and within 30 days of the end of the term they relate to.

Section 1

To be completed by the fee payer. If the claim is for a pupil absence of 14 consecutive days or more, Section 3 must be completed by the pupil's medical practitioner.

Name of pupil	
Date of birth	
School name	
Name of fee payer	
Address of fee payer	
Postcode	
Contact number	
Email address	
How do you wish to be contacted? (Please tick all the apply)	☐ Phone ☐ Email
Date of incident/illness	

Date of incapacity:

From	
To	

Please describe the circumstances leading up to and surrounding the incident:

Please confirm the number of days/terms missed that you are claiming for:	
Have you received any refund from the school for your fees? If so how much?	
Please confirm the amount you are claiming for:	
Are you aware of any other insurance that may cover this loss?	☐ Yes ☐ No

Once Section 1 and 3 of the form have been completed, it must be returned to the school to complete Section 2 who will forward to the Claims Team: pupil.claims@howdeninsurance.co.uk

Section 2

To be completed by the school.

Name of school	
Postcode	
School policy number	
Name of pupil	
Boarder or day pupil:	☐ Boarder ☐ Day
Total termly fees	

Dates of absence:

First day	
Last day	

Please confirm that the school fees being claimed have been paid and are not outstanding:	☐ Paid ☐ Outstanding
Name of school official	
Signature of school official	
Date	

Section 3

To be completed by the pupil's medical practitioner if the claim is for a pupil absence of 14 consecutive days or more.

Are you the patient's usual doctor?	☐ Yes	☐ No

Please give full details of the injury/illness and dates of incapacity

When did the patient first receive medical attention for this condition?

Has the patient ever suffered with this or any similar condition before this incident?	☐ Yes	☐ No

If yes, please give details

Doctor's name	
Postcode	
Telephone number	
Signature	
Date	
Validation stamp	

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