# Personal Accident & Sickness Claim Form

**THIS SECTION OF THE CLAIM FORM IS FOR YOU TO RETAIN**

If you or your employee have sustained an injury or contracted an illness which may be covered under your policy, please complete and return the attached form without delay to enable us to consider your claim. Kindly note that any delay may prejudice our position resulting in us being unable to consider your claim.

For Group Policies, Sections A to E can be completed by either the Insured Company or the Insured Person, however, both parties must thoroughly check the contents of the form and sign the relevant declaration. Section F must be completed by the Insured Persons usual Doctor.

*In addition to this claim form, we will require all original medical certificates throughout the entire period of disability.*

## Point 1

**Customer Service Charter**

We aim to provide:

- A high quality, efficient and helpful service
- A swift and courteous response to all claims forms, associated documentation or correspondence sent to Aviva
- Prompt payment in respect of valid claims following their authorisation
- A speedy indication that a claim cannot be met until further information is received
- Up to date information on the current position of your claim if it cannot be paid quickly
- We have agreed to comply with the Association of British Insurers Claims Code, a copy of which is available on request from us or from the ABI website at www.abi.org.uk

**Fraud Prevention and Detection**

In order to prevent and detect fraud we may at any time:

- Share information about you with other organisations and public bodies including the Police;
- Check and/or file your details with fraud prevention agencies and databases, and if you give us false or inaccurate information and we suspect fraud, we will record this. We and other organisations may also search these agencies and databases to:
  - Help make decisions about the provision and administration of insurance, credit and related services for you and members of your household;
  - Trace debtors or beneficiaries, recover debt, prevent fraud and to manage your accounts or insurance policies;
  - Check your identity to prevent money laundering, unless you furnish us with other satisfactory proof of identity;
- Undertake credit searches and additional fraud searches
- We can supply on request further details of the database we access or contribute to.

In assessing any claims made, the insurer or its agents may undertake checks against publicly available information (such as electoral roll, county court judgements, bankruptcy orders or repossessions). Information may also be shared with other insurers either directly or via those acting for the insurer (such as loss adjusters or investigators).

## Point 2

**Sensitive Data**

In order to assess the terms of the insurance contract or administer claims which arise, the insurer may need to collect data which the Data Protection Act defines as sensitive (such as medical history or criminal convictions). Proceeding with this application you will signify your consent to such information being processed by the insurer or its agents.

## YOUR RIGHTS/ACCESS TO MEDICAL REPORTS ACT 1988

As, under the terms of your policy, we require completion of a medical report by the doctor who is caring for you, to enable us to deal with your claim, we need your consent by signing in the space indicated below. Before doing so, however, you should read this note carefully as it sets out your rights under the Access to Medical Reports Acts 1988 and the procedures for dealing with Reports.

You do not have to give your consent to our being provided with the report but, if you do, you have the right to tell the doctor you wish to see the report before it is sent to us, in which case the doctor cannot send it to us unless either he has shown it to you, or 21 days have passed without your having contacted your doctor about arrangements for you to see it. Of course, the quicker you act, the quicker your claim can be considered, and we may not be able to proceed with your claim in the absence of medical information.

Whether or not you say you wish to see the report before it is sent to us, the doctor must let you see a copy for up to six months after it is supplied to us, if you ask.

If you ask the doctor for a copy of the report, he can charge you a reasonable fee to cover his costs.

Once you have seen a report before it is sent to us, the doctor cannot submit it until he has your consent. You can write to the doctor asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your views on any part where you and the doctor are not in agreement and which the doctor is not prepared to alter.

The doctor is not obliged to let you see any part of a report if in his opinion, that would be likely to cause serious harm to your physical or mental health or that of others or:

- would indicate the doctors intentions towards you, or
- if disclosure would be likely to reveal information about, or the identity of, another person who has supplied information about you unless that person has consented or the information relates to or
- the information has been supplied by, a health professional involved in caring for you.

In such cases, the doctor must notify you and you will be limited to seeing any remaining part of the report. If it is the whole report which is affected, he must not send it to us unless you give your consent.

Before signing the consent form at the foot of this letter you should read the following summary of your rights and the detailed explanation above.

(a) You can withhold your consent but if you should do so your insurers may be unable to process your claim.
(b) You can see the report before it is sent to us. You may request a copy of the report during the following six months.
(c) You can ask the doctor if he will amend any part of the report which you consider to be incorrect or misleading. If the doctor is not in agreement you may append your comments.
(d) Your doctor can in certain circumstances withhold from you the report or any part of it.

I wish to see the report before it is sent to the company ☐

I do not wish to see the report before it is sent to the company ☐

*Please tick one box only

## CONSENT TO OBTAIN A MEDICAL REPORT

I have been informed of my statutory rights under the Access to Medical Reports Act 1988 as explained above and in connection with my insurance claim I hereby consent to Aviva Insurance UK Limited seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health in connection with this claim and I agree that a copy of this consent shall have the validity of the original.

Signed ____________________ Date ____ / ____ / ____

Name ____________________ Policy No. ____________________
(please print)

## Section F – Medical Report *continued*

### SECTION 3 – GENERAL (to be completed by medical practitioner for all claims)

Is the incapacity related to more than one complaint? YES ☐ NO ☐

If YES, please give details

Are you prepared to certify that the claimant is/has been TOTALLY disabled from attending to his/her business or occupation as a ______ YES ☐ NO ☐

If so, what date did TOTAL disablement commence? / /

Has TOTAL disability been continuous since this date? YES ☐ NO ☐

If NO, please give details

Please state date claimant was fit to return to work / /

If the claimant is now PARTIALLY disabled, please state the date TOTAL disablement ceased / /

If the claimant is PARTIALLY disabled, what portion of duties do you feel the claimant is capable of attending to?

If the claimant is still incapacitated, please state the expected further duration of disability

Please give details of any ongoing medication/treatment/investigations

Have you or do you intend to refer the claimant for other medical opinion/treatment?

General remarks

**I certify that the information I have given is correct.**

Signature

Full Name

Qualification

Doctors' stamp
(or surgery address)

Date / /

# Personal Accident Claims

PO Box 83
Surrey Street
Norwich NR1 3JP
Tel: 01603 844869 Fax: 01603 840637

## Section A – Policyholder/Claimant Details

Name of Policyholder

Policy Number

Full name of Claimant

Date of Birth / /

Address of Claimant

Postcode

Telephone Number

Claimant's occupation

Are you self-employed? YES ☐ NO ☐

Business address

Date of Employment / /

Postcode

Nature of Business

Please give details of what your normal working day involves

How much of your day is taken up by administrative duties?

Please give details of all income received during period of disability. (figures given should be per week)

State benefits/SSP

Other Insurance Policy benefits

Other

Name of any other insurance covering this period of incapacity

If you are self-employed, will your business cease to operate during your period of incapacity? YES ☐ NO ☐

**Did you suffer an accident? If YES, please complete Section B. For all other claims, please complete Section C.**

## Section B – Personal Accident

Date of Accident / /

Time of Accident am/pm

Where accident occurred

Full description of accident

What injuries did you sustain?

Have you ever had any previous medical condition relating to this body part? YES ☐ NO ☐

If YES, please give details

If injury was as a result of a road traffic accident, was it reported to the Police? YES ☐ NO ☐

If YES, please give address of police station and accident reference number

Is there any pending prosecution against you? YES ☐ NO ☐

## Section C – Sickness

State as precisely as you can what symptoms you have and what diagnosis your doctor has given

Date when illness began or when you became aware of symptoms  /  /

Have you suffered from this or similar illness previously? YES ☐ NO ☐

If YES, please give details

If disease, where was this contracted?

## Section D – General Questions

Date you were unable to work due to accident/sickness  /  /

Are you still unable to work? YES ☐ NO ☐

If NO, please state date you returned to work  /  /

Have you been TOTALLY disabled from carrying out your usual occupation? YES ☐ NO ☐

If NO, please give details of duties/hours undertaken

Date from which you have been able to undertake partial duties  /  /

Name and address of usual doctor

Have you attended any other medical practioner e.g. hospital/osteopath? YES ☐ NO ☐

If YES, please provide name and address

## Section E – Hospitalisation

Were you admitted to hospital as an in-patient?

Date of admission  /  /  Time of admission  am/pm

Date of discharge  /  /  Time of discharge  am/pm

**Declaration**

I/We declare the above particulars to be true and complete in every respect and that no material information has been withheld. I authorise Aviva to obtain information from other Insurers and also my employer or accountant. I will inform Aviva immediately should I undertake any form of work, either paid or unpaid.

Claimant's signature  Date  /  /

I/We declare the above particulars to be true and complete to the best of my knowledge and belief.

Policyholder's signature  Date  /  /

Please print name and position held

**Fraud Warning**

The submission of a fraudulent or intentionally exaggerated claim or the submission of false documentation or declaration in relation to part of or the whole claim – may result in voidance of your policy or refusal of your entire claim.

## Section F – Medical Report

***The claimant must obtain at his/her own expense the following report from a duly qualified registered Medical Practioner.***

Claimants full name ______ Date of Birth __ / __ / __

Are you the claimant's usual medical attendant? YES ☐ NO ☐ If YES, for how long? ______

When did the claimant first consult any Doctor for the present injury/illness? ______

When was the last time the claimant consulted you? ______

Has the current condition been caused by an accident? YES ☐ NO ☐

**If YES, please complete Section 1 – Accident, If NO, please complete Section 2 – Sickness.**

### SECTION 1 – ACCIDENT

Accident circumstances ______

Nature and extent of injuries sustained ______

Are the symptoms from which the claimant suffers due to the accident alone? YES ☐ NO ☐

If NO, please give details of anything in the claimant's previous history which might have contributed directly or indirectly to this injury or the symptoms.

Are you aware of anything in the claimant's previous history which may delay recovery in any way? YES ☐ NO ☐

If YES, please give details.

### SECTION 2 – SICKNESS

Please describe the nature of the illness/condition

Please state origin/cause if known ______

Please state history of condition confirming date symptoms arose

Are you aware of anything in the claimant's previous history which may have contributed directly or indirectly to the onset of this illness/condition? YES ☐ NO ☐

If YES, please give full details

Is there anything which may delay recovery?

Aviva Insurance UK Limited
Registered in England Number 99122
Registered Office: Surrey Street Norwich NR1 3NG
Authorised and regulated by the Financial Services Authority

BPAAS8038 06.2009 (A)