Personal Accident Claim Form

AIG Direct

This form has been designed to help you provide all the information we need to process your claim quickly. Failure to complete this form correctly may delay your claim. We recommend you have your policy to hand for reference.

If you need to attach additional sheets please use the same section headings as detailed on this form.

Please complete this form in BLOCK CAPITALS and return it to: **AIG Direct Claims Department, The AIG Building, 2-8 Altyre Road, Croydon, Surrey, CR9 2LG.**

If you require assistance to complete your form or have any questions please call 020 8662 8101 and a member of our Claims Team will be able to help you.

Please complete Sections 1, 2 and 3 and then ask your GP or consultant to complete Section 4. If any question is not applicable, please state N/A.
PLEASE MAKE SURE YOU SIGN AND DATE THIS CLAIM FORM (SEE SECTION 5).

SECTION 1: Policy Details

POLICY NUMBER:

OFFICE USE ONLY:

CLAIM NUMBER:

SECTION 2: Personal Information – The Claimant

Please complete **ALL** questions.

NAME IN FULL (INCLUDING TITLE):

ADDRESS:

POSTCODE:

DATE OF BIRTH: dd | mm | yy

AGE AT TIME OF ACCIDENT:

DAYTIME TEL NO:

MOBILE TEL NO:

EMAIL:

NAME OF EMPLOYER/COMPANY (IF OVER 16 YEARS OF AGE):

ADDRESS OF EMPLOYER (IF SELF EMPLOYED, PLEASE STATE BUSINESS ADDRESS):

POSTCODE:

EMPLOYER'S BUSINESS:

OCCUPATION/TITLE:

DESCRIPTION OF DUTIES (IF OVER 16 YEARS OF AGE):

NAME OF POLICY HOLDER (INCLUDING TITLE):

RELATION TO CLAIMANT:

SECTION 3: Accident Details

Please complete **ALL** questions. If you need to provide additional information please use separate sheet(s) of paper and attach with this form. **Your claim cannot be processed without this information.**

Please specify exact date and time of incident:

TIME: DATE: dd | mm | yy

ON WHAT DATE DID YOU STOP PERFORMING ALL YOUR OCCUPATIONAL DUTIES: dd | mm | yy

Have you engaged in any work since disability began? ☐ Yes ☐ No

If Yes:

NATURE OF WORK:

DATE WORK COMMENCED: dd | mm | yy

IS THIS FULL TIME OR PART TIME?

If No please confirm:

HOW LONG HAVE YOU BEEN TOTALLY DISABLED AND UNABLE TO PERFORM ANY PART OF YOUR OCCUPATION?

Are you medically signed off from work? ☐ Yes ☐ No

If Yes, please attach a copy of the latest medical certificate to the claim form.

STATE DATE YOU EXPECT TO RETURN TO WORK dd | mm | yy

Continue overleaf

DESCRIBE EXACTLY WHERE AND HOW THE ACCIDENT OCCURRED:

DESCRIBE INJURIES SUSTAINED:

For what period were you confined to hospital:

FROM: dd | mm | yy TO: dd | mm | yy

For what period were you confined to the house:

FROM: dd | mm | yy TO: dd | mm | yy

If the injury was as a result of criminal assault or a Road Traffic Accident, was the accident reported to the police? ☐ Yes ☐ No

If Yes:

ADDRESS OF POLICE STATION:

POSTCODE:

INCIDENT REPORT NUMBER:

NAME OF POLICE OFFICER (IF RELEVANT):

Please give name(s) and address(es) of every doctor consulted for the present injury, including your GP:

NAME OF YOUR GP:

ADDRESS:

POSTCODE: TELEPHONE NO.:

NAME:

ADDRESS:

POSTCODE: TELEPHONE NO.:

NAME:

ADDRESS:

POSTCODE: TELEPHONE NO.:

NAME:

ADDRESS:

POSTCODE: TELEPHONE NO.:

PLEASE CONFIRM WHICH SECTIONS OF THE POLICY DOCUMENT YOU ARE CLAIMING UNDER:

Are you entitled to disability benefits from:

(a) any other insurer? ☐ Yes ☐ No If Yes please provide details of each insurer:

NAME:

ADDRESS:

POSTCODE:

POLICY NUMBER:

NAME:

ADDRESS:

POSTCODE:

POLICY NUMBER:

(b) the DWP? ☐ Yes ☐ No If Yes please send a copy of the disability assessment.

Continue overleaf

SECTION 4: Doctor's Statement - This section of the form must be completed by a doctor to avoid delay in assessing the claim

ANY FEE PAYABLE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE CLAIMANT AND NOT THE COMPANY.

NAME OF PATIENT:

DATE OF ACCIDENT: dd | mm | yy

Are you the patient's usual Medical Attendant? ☐ Yes ☐ No

Is the claimant's disability due **solely** to this accident? ☐ Yes ☐ No

ACCIDENT DETAILS:

INJURY SUSTAINED (IF THIS INVOLVES AN EYE OR LIMB, STATE LEFT OR RIGHT):

DIAGNOSIS:

TREATMENT:

Was an operation performed? ☐ Yes ☐ No

IF YES, PLEASE GIVE DETAILS, INCLUDING OPERATION DATE(S):

Were any fractures sustained? ☐ Yes ☐ No

IF YES, PLEASE CONFIRM SITE OF FRACTURE(S):

Is there any evidence of bone disease or osteoporosis? ☐ Yes ☐ No

IF YES, PLEASE CONFIRM DATE DIAGNOSED: dd | mm | yy

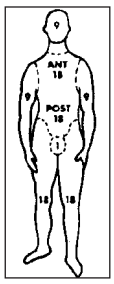
Were any dislocations sustained? ☐ Yes ☐ No

Did the dislocation require reduction under anaesthesia? ☐ Yes ☐ No

Is there any indication that alcohol was a contributory factor? ☐ Yes ☐ No

Has the patient sustained a third degree burn? ☐ Yes ☐ No

If 'Yes', please indicate the area of burns on the chart. Please give your assessment of the percentage of body surface which has been affected by third degree burns by reference to the 'Rule of Nine'



For what period was the patient confined to hospital:

FROM: dd | mm | yy TO: dd | mm | yy

For what period was the patient confined to bed:

FROM: dd | mm | yy TO: dd | mm | yy

For what period was the patient confined to the house:

FROM: dd | mm | yy TO: dd | mm | yy

Continue overleaf

For what period was the patient unable to perform any part of their occupation:

FROM: dd | mm | yy

TO: dd | mm | yy

For what period was the patient able to perform part but not all of their occupation:

FROM: dd | mm | yy

TO: dd | mm | yy

If the patient has not returned to work, when do you think they will be able to resume employment?

APPROXIMATE DATE: dd | mm | yy

Is the patient Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed ☐

Has the patient previously suffered this type of injury? ☐ Yes ☐ No

IF YES, PLEASE GIVE DETAILS, INCLUDING DATE(S):

Is the patient suffering from any other medical condition or disability which is affecting their recovery? ☐ Yes ☐ No

IF YES, PLEASE SPECIFY:

TOTAL NUMBER OF VISITS:

DATE TREATMENT FIRST SOUGHT: dd | mm | yy

DATE OF LAST VISIT: dd | mm | yy

In your opinion do you think the patient will be left with a permanent disability **solely** as a result of the accident? ☐ Yes ☐ No

IF YES, PLEASE GIVE FULL DETAILS (INCLUDING TREATMENT, MEDICATION, CONSULTANT REFERRALS, CONSULTANT NAME(S)/TITLE(S)/ADDRESS(ES) ETC…):

DECLARATION: I hereby certify that my answers to the questions in Section 4 are correct and true to the best of my knowledge and belief

SIGNATURE:

DATE: dd | mm | yy

PRINT NAME:

TITLE:

HOSPITAL/GP ADDRESS OR STAMP:

Continue overleaf

SECTION 5: Declaration to be completed by the insured

Access to Medical Records Act, 1988/Access to Personal Files and Medical Reports (Northern Ireland) Order 1991/Access to Health Records and Reports Act 1993 (Isle of Man) ('The Acts')

To enable AIG Direct to assess your claim, it may be necessary to obtain medical evidence. Any reports which are requested from your doctors are subject to the Acts. (Please note that Reports requested from Doctors appointed by AIG Direct are not subject to the Acts.) In summary your statutory rights are as follows.

1. A Medical Report cannot be requested from any doctor who has attended you, without your written authority.
2. You do not have to give your consent. If you do consent, you can say whether you wish to see the report before it is supplied. If you do not give consent we may be unable to proceed with your claim.
3. If you say you wish to see the report, we will write to your doctor and tell them, and advise you that we have done so. You will then have 21 days from the date of notification to contact the doctor to make arrangements for you to see the report.
4. The medical practitioner will be informed that you wish to have access to the report and will allow 21 days from the date of the notification for you to see and approve it before it is supplied to us. If the medical practitioner has not heard from you in writing within 21 days of the application for the report being made, he/she will assume that you do not wish to see the report and that you consent to it being supplied.
5. If you say that you do not wish to see the report, we do not have to notify you if we apply for one.
6. Whether or not you say you wish to see the report before it is sent to us, you may ask your doctor to show you a copy of the report for up to six months after it is supplied. The practitioner may a charge a reasonable fee for the cost of supplying a report not exceeding £50.
7. If you see a report before it is sent to us, the doctor cannot submit it until you give your consent. You can write to the doctor, asking that any part of the report which you consider to be incorrect or misleading be amended and to have attached to the report a statement of your views on any part where you and the doctor are not in agreement.
8. The doctor is not obliged to let you see any part of a report if:

   a) In his/her opinion it would be likely to cause serious harm to your physical or mental health, or that of others.

   b) It would indicate the doctor's intentions towards you.

   c) Disclosure would be likely to reveal information relating to, or the identity of, someone else that has supplied information about you, unless that person has consented.

I hereby authorise any physician or other person who has attended or examined me to furnish the Company or its authorised representative with any and all information with respect to any illness, sickness or injury, medical history, consultation, prescriptions or treatment and copies of all Hospital or medical records.

I do ☐ do not ☐ wish to see a copy of the medical report before it is sent to the Company (please tick).

A photocopy of this authorisation shall be considered as effective and valid as the original.

SIGNATURE:	DATE dd | mm | yy	PRINT NAME:

Data Protection

How we use Personal Information

AIG Direct is committed to protecting the privacy of customers, claimants and other business contacts.

"Personal Information" identifies and relates to you or other individuals (e.g. your dependants). By providing Personal Information you give permission for its use as described below. If you provide Personal Information about another individual, you confirm that you are authorised to provide it for use as described below.

The types of Personal Information we may collect and why - Depending on our relationship with you, Personal Information collected may include: identification and contact information, payment card and bank account, credit reference and scoring information, sensitive information about health or medical condition or criminal conviction, and other Personal Information provided by you. Personal Information may be used for the following purposes:

- Insurance administration, e.g. communications, claims processing and payment
- Assistance and advice on medical and travel matters
- Management and audit of our business operations
- Prevention, detection and investigation of crime, e.g. fraud and money laundering
- Establishment and defence of legal rights
- Legal and regulatory compliance, including compliance with laws outside your country of residence
- Monitoring and recording of telephone calls for quality, training and security purposes
- Marketing, market research and analysis

Sharing of Personal Information - For the above purposes Personal Information may be shared with our group companies, brokers and other distribution parties, insurers and reinsurers, credit reference agencies, healthcare professionals and other service providers. Personal Information will be shared with other third parties (including government authorities) if required by law. Personal information (including details of injuries) may be recorded on claims registers shared with other insurers. We are required to register all third party claims for compensation relating to bodily injury to workers' compensation boards. We may search these registers to detect and prevent fraud or to validate your claims history or that of any other person or property likely to be involved in the policy or claim.

Continue overleaf

Personal Information may be shared with prospective purchasers and purchasers, and transferred upon a sale of our company or transfer of business assets.

International transfer - Due to the global nature of our business Personal Information may be transferred to parties located in other countries, including the United States and other countries with different data protection laws than in your country of residence.

Security and retention of Personal Information – Appropriate legal and security measures are used to protect Personal Information. Our service providers are also selected carefully and required to use appropriate protective measures. Personal information will be retained for the period necessary to fulfil the purposes described above.

Requests or questions - To request access or correct inaccurate Personal Information, or to request the deletion or suppression of Personal Information, or object to its use, please e-mail: DataProtectionOfficer@aig.com or write to Data Protection Officer, Legal Department, AIG Europe Limited, The AIG Building, 58 Fenchurch Street, London, EC3M 4AB. More details about our use of Personal Information can be found in our full Privacy Policy at www.aigdirect.co.uk/privacy-policy or you may request a copy using the contact details above.

Declaration and Consents

1. I declare that all statements I have made are true and complete. I consent to AIG Direct or their Agents undertaking any enquiries they consider necessary concerning the admission and continuation of the claim.
2. I have read and I understand my statutory rights under the Access to Medical Reports Act 1988/Access to Personal Files and Medical Reports (Northern Ireland) Order 1991/Access to Health Records and Reports Act 1993 (Isle of Man) ('The Acts') as outlined above and I consent to AIG Direct or their Agents seeking medical information, including copies of my medical records, from any doctor who at any time has attended me, concerning anything which affects my physical or mental health.
3. I have read and understood the section on Data Protection and
   - I consent explicitly to AIG Direct or their Agents being provided with confidential information, concerning the application for this insurance, including but not limited to sensitive information concerning my physical and/or mental health or condition from any third party.
   - I authorise the release of confidential information, including but not limited to sensitive information concerning my physical and/or mental health or condition obtained by AIG Direct or their agents, to my doctors or any doctors or specialists appointed by AIG Direct or their Agents in relation to the claim and to any third party, including but not limited to my employer or my employer's nominated intermediary, who requires such information for lawful purposes.

SIGNATURE:

DATE

dd | mm | yy

PRINT NAME IN FULL:

Any problems completing this claim form? Please contact us on: 020 8662 8101