Claim Form

Personal Accident & Sickness

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.

Customer Service Charter

We aim to provide:

- A high quality, efficient and helpful service.
- A swift and courteous response to all claim forms, associated documentation or correspondence sent to Aviva.
- Prompt payment in respect of valid claims following their authorisation.
- A speedy indication if 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.

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;
- Undertake credit searches and additional fraud searches;
- 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.

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 judgments, 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).

Claims History

Under the conditions of your policy you must tell us about any insurance related incidents (such as accidents, bodily injury, illnesses or incidents whilst travelling on business) whether or not they give rise to a claim.

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.

FAO
GPA Claims Department
4th Floor, The Observatory
Chapel Walks, Manchester
M2 1HL
Tel: 0800 051 6583
Fax: 0161 931 8024
Email: gpaclaims@aviva.com

PLEASE WRITE IN BLACK INK AND USE BLOCK CAPITAL LETTERS.
ALL SECTIONS MUST BE COMPLETED OR MARKED `NOT APPLICABLE'.

SECTION A - POLICYHOLDER/CLAIMANT DETAILS

Name of Policyholder

Policy No

Claimant Details

Title

First Name

Last Name

Date of Birth

Email Address

Full Address including postcode

Contact Daytime Telephone No.

Contact Evening Telephone No.

Claimant's Occupation Details

Occupation

Are you self-employed

Yes ☐ No ☐

Date of Employment

Full Occupation Address including postcode

Nature of Occupation

How many hours a day do you perform admin duties?

Full Occupation Address including postcode

Please give details of all income received during the 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 your 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

Please give exact date and time of the Accident:

Date: Time: AM ☐ PM ☐

Where did the accident occur?

Please provide a full description of the 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 the police station and accident reference number?

Is there any pending prosecution against you? Yes ☐ No ☐

SECTION C - SICKNESS

What injuries did you sustain?

Please provide the date when the illness began or when you became aware of symptoms:

Date:

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

Please provide the date when you were unable to work due to accident/sickness:

Date:

Are you still unable to work? Yes ☐ No ☐

If NO, please state the date you returned to work:

Date:

Have you been TOTALLY disabled from carrying out your usual occupation? Yes ☐ No ☐

If NO, please give details of duties/hours undertaken:

Please provide the date from which you have been able to undertake partial duties:

Date:

Please provide the name and address of your usual doctor:

Have you attended any other medical practitioner e.g. hospital/osteopath? Yes ☐ No ☐

If YES, please provide names and address:

SECTION E - HOSPITALISATION

Date of admission: Time of admission: AM ☐ PM ☐

Date of discharge: Time of discharge: AM ☐ PM ☐

PAYEE'S BANK DETAILS

If we approve your claim, we can credit the money direct to your bank account. This method is quicker, safer and more reliable than payment by cheque. If you would like us to do this, please complete the following:-

Name of your Bank/Building Society:

Address including postcode:

Bank Sort Code: ☐☐ - ☐☐ - ☐☐

Bank Account Number: ☐☐☐☐☐☐☐☐

Name of Account Holder(s):

DECLARATION

CLAIMANT 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.

SIGNED DATE

POLICYHOLDER DECLARATION

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

SIGNED DATE

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

This section must be fully completed by a duly qualified registered Medical Practitioner - any fee for completion of this section is the responsibility of the Claimant.

Claimant's 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 Part 1 - Accident, If NO, please complete Part 2 - Sickness.

PART 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 F - MEDICAL REPORT (Continued)

PART 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?

PART 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:

SECTION F - MEDICAL REPORT (Continued)

PART 3 - GENERAL (to be completed by medical practitioner for all claims) (Continued)

Please state the date the 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.

SIGNED

DATE

Position held in Hospital:

Qualifications:

Please use validation stamp or complete in block capitals:-

Hospital Name:

Address:

Telephone No:

VALIDATION STAMP

Thank you for your assistance in completing this form.

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 Act 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 page, 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) You 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 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(Please print)	POLICY NO