

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** or by email to aigdirect.claims@aig.com.

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

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 home:

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

If the injury was as a result of an assault or a road traffic accident, was this report to the Police?

Yes No

If Yes:

ADDRESS OF POLICE STATION:

POSTCODE:

INCIDENT REPORT NUMBER:

NAME OF POLICE OFFICER (IF RELEVANT):

Please give details of any Doctor who you have consulted for your injury including the name of 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 SECTION 5 OF THE POLICY DOCUMENT YOU ARE CLAIMING UNDER:

Are you entitled to disability benefits from the DWP or any other insurance/pension company?

If so please provide further details of this and the contact details of who you have the claim with:

NAME:

ADDRESS:

POSTCODE:

POLICY NUMBER:

NAME:

ADDRESS:

POSTCODE:

POLICY NUMBER:

In the event that benefit is due, please confirm if you require cheque or bank transfer. For bank transfer, please confirm the following:

ACCOUNT PAYEE (OF INSURED UNLESS A MINOR):

ACCOUNT NUMBER:

SORT CODE:

BANK NAME AND POSTAL ADDRESS:

SECTION 4 – Doctors Statement – This section of the form must be completed by a Doctor to avoid delay in the assessment to 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:

Has surgery been performed? Yes No

IF YES, PLEASE GIVE DETAILS, INCLUDING SURGERY 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

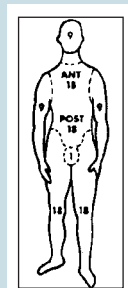
Were any dislocations sustained? Yes No

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 our 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

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 incl GMC NUMBER:

HOSPITAL/GP ADDRESS OR STAMP:

SECTION 5: Declaration to be completed by the insured
Access to Medical Records / Medical Reports Consent Form

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) ("Acts")

To enable American International Group UK Limited or their agents (the Company) to assess your claim, it may be necessary to obtain medical evidence. Any medical reports which are requested from your Doctor (your GP, medical specialists) are subject to the Acts. (Please note that medical reports requested from Doctors appointed by the Company are not subject to the Acts).

In summary your statutory rights under the Acts are as follows:

1. A medical report cannot be requested from any Doctor, who has attended you, without your written authority (consent).
2. You may withhold your consent. However, without your consent we may be unable to proceed with your claim.
3. If you do consent you can indicate whether you wish to see the report before it is supplied to us.
 - a) If you wish to see the report, we will notify your Doctor accordingly. We will advise you that we have done so (notification).
 - b) You will then have 21 days from the date of the notification to contact the Doctor, in writing, to make arrangements to see the report.
 - c) The Doctor will allow 21 days for you to see the report before it is supplied to us.
 - d) If the Doctor has not heard from you within 21 days of the notification he/she will assume you do not wish to see the report and that you consent to it being supplied.
4. If you do not indicate that you wish to see the report, we do not have to notify you if we apply for such report.
5. When you see the report, if there is anything in it that you consider incorrect or misleading you can request, in writing, that the Doctor amends the report, but the Doctor is not obliged to do so. If the Doctor refuses to amend the report you may: (a) withdraw consent for the report to be issued, (b) ask the Doctor to attach to the report a statement setting out your own views, (c) agree to the report being issued unchanged.
6. Whether or not 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. Please note that the Doctor is obliged to retain the report for at least 6 months after it was supplied. The Doctor may charge a reasonable fee for the cost of supplying the report but not exceeding £50.
7. The Doctor is not obliged to show you any parts of the report that he/she believes might cause serious harm to your physical or mental health or that of others, or it would indicate the Doctor's intentions towards you. If this is the case, the Doctor will tell you if your access to the report is limited

Please confirm the full name and postal address of your Doctor

NAME OF GP:

ADDRESS:

PHONE NUMBER

CONSULTANT NAME

ADDRESS:

PHONE NUMBER

I have read my statutory rights under the Acts as outlined above and by signing this form I consent to the Company 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 relating to the condition (s) that gives rise to my claim.

I also authorise any physician or other person to furnish American International Group UK Limited or their agents 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 relating to the condition (s) that gives rise to my claim.

Do you wish to see the report before it is sent to the Company? Yes No

SIGNED:

DATE

dd | mm | yy

FULL NAME:

IF YOU ARE SIGNING ON BEHALF OF THE CLAIMANT, PLEASE STET THE REASON AND YOUR RELATION SHIP:

Data Protection

How we use Personal Information

American International Group UK Limited 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 partner or other members of your family). If you provide Personal Information about another individual, you must (unless we agree otherwise) inform the individual about the content of this notice and our Privacy Policy and obtain their permission (where possible) for sharing of their Personal Information with us.



The types of Personal Information we may collect and why – Depending on our relationship with you, Personal Information collected may include: contact information, financial information and account details, credit reference and scoring information, sensitive information about health or medical conditions (collected with your consent where required by applicable law) as well as other Personal Information provided by you or that we obtain in connection with our relationship with you. Personal Information may be used for the following purposes:

- Insurance administration, e.g. communications, claims processing and payment
- Make assessments and decisions about the provision and terms of insurance and settlement of claims
- Assistance and advice on medical and travel matters
- Management of our business operations and IT infrastructure
- 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 and regulations outside your country of residence)
- Monitoring and recording of telephone calls for quality, training and security purposes
- Market research and analysis

Sharing of Personal Information - For the above purposes Personal Information may be shared with our group companies and third parties (such as brokers and other insurance 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 laws or regulations. 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 prevent, detect and investigate fraud or to validate your claims history or that of any other person or property likely to be involved in the policy or claim. 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, China, Mexico Malaysia, Philippines, Bermuda and other countries which may have a data protection regime which is different to that in your country of residence). When making these transfers, we will take steps to ensure that your Personal Information is adequately protected and transferred in accordance with the requirements of data protection law. Further information about international transfers is set out in our Privacy Policy (see below).

Security of Personal Information – Appropriate technical and physical security measures are used to keep your Personal Information safe and secure. When we provide Personal Information to a third party (including our service providers) or engage a third party to collect Personal Information on our behalf, the third party will be selected carefully and required to use appropriate security measures.

Your rights – You have a number of rights under data protection law in connection with our use of Personal Information. These rights may only apply in certain circumstances and are subject to certain exemptions. These rights may include a right to access Personal Information, a right to correct inaccurate data, a right to erase data or suspend our use of data. These rights may also include a right to transfer your data to another organisation, a right to object to our use of your Personal Information, a right to request that certain automated decisions we make have human involvement, a right to withdraw consent and a right to complain to the data protection regulator. Further information about your rights and how you may exercise them is set out in full in our Privacy Policy (see below).

Privacy Policy - More details about your rights and how we collect, use and disclose your Personal Information can be found in our full Privacy Policy at: <https://www.aig.co.uk/privacy-policy> or you may request a copy by writing to: Data Protection Officer, American International Group UK Limited, The AIG Building, 58 Fenchurch Street, London EC3M 4AB.or by email at: dataprotectionofficer.uk@aig.com

Declaration

BY SIGNING THIS FORM I/WE DECLARE THAT THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT A FALSE DECLARATION MAY INVALIDATE MY CLAIM AND COULD RESULT IN PROSECUTION

SIGNATURE: _____ DATE _____

dd | mm | yy

PRINT NAME: _____

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

