Hospital Cash Plan 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 Insurance Health Protection Unit, Claims Department, American International Group UK Limited, The AIG Building, 2-8 Altyre Road, Croydon CR9 2LG.**

If you require assistance to complete your form or have any questions please call the number below and a member of our Claims Team will be able to help you: **Telephone: 020 8662 8101 or email aigdirect.claims@aig.com.**

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: d d | mm | y y

AGE OF CLAIMANT:

DAYTIME TEL NO:

MOBILE TEL NO:

EMAIL:

NAME OF POLICYHOLDER (INCLUDING TITLE):

RELATION TO CLAIMANT:

NAME OF GP:

ADDRESS OF GP:

POSTCODE:

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 3: Hospital Details

Please specify reason for admission ☐ Illness ☐ Accident

If Illness:

WHAT WAS THE NATURE OF THE ILLNESS:

DATE OF FIRST CONSULTATION: d d | mm | y y

Have you suffered from this type of illness before? ☐ Yes ☐ No

IF YES, PLEASE STATE WHEN: d d | mm | y y

The following information is required for claims resulting from either an accident or an illness:

NAME OF ATTENDING HOSPITAL DOCTOR:

NAME AND ADDRESS OF HOSPITAL:

Continue overleaf

If Accident:

HOW DID IT HAPPEN:

HOW DID IT HAPPEN:

For what period were you confined to hospital:

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

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

Are you claiming Recuperation benefit for a hospital stay of 7 days or more ☐ Yes ☐ No

Did you attend hospital as an outpatient? ☐ Yes ☐ No

If you attended hospital as an outpatient, please specify the dates below:

DATE OF VISIT: dd|mm|yy

DATE OF VISIT: dd|mm|yy

DATE OF VISIT: dd|mm|yy

DATE OF VISIT: dd|mm|yy

DATE OF VISIT: dd|mm|yy

DATE OF VISIT: dd|mm|yy

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/ILLNESS: dd|mm|yy

CLAIMANT'S HOSPITAL NUMBER:

Is the patient's incapacity due **solely** to this accident/illness? ☐ Yes ☐ No

Please give either:

FULL DETAILS OF INJURY SUSTAINED:

Or:

FULL DIAGNOSIS OF ILLNESS:

WHEN DID SYMPTOMS FIRST APPEAR: dd|mm|yy

DATE OF FIRST CONSULTATION: dd|mm|yy

DATE THE CONDITION WAS FIRST DIAGNOSED: dd|mm|yy

PLEASE CONFIRM DATE TREATMENT WAS FIRST GIVEN: dd|mm|yy

Was an operation performed? ☐ Yes ☐ No

IF YES, PLEASE GIVE DETAILS (INCLUDING DATES):

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

IF YES, PLEASE GIVE DETAILS (INCLUDING DATES):

Did this contribute to their present condition? ☐ Yes ☐ No

IF YES, PLEASE GIVE DETAILS:

Did this result in the patient's period of hospitalisation being extended? ☐ Yes ☐ No

IF YES, PLEASE ESTIMATE BY HOW MANY DAYS:

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

IF YES, PLEASE SPECIFY:

Continue overleaf

For what period was the patient confined to hospital as an inpatient?

FROM: dd|mm|yy	TO: dd|mm|yy
NAME OF WARD THE PATIENT WAS ADMITTED TO:	TYPE OF WARD:

Did the patient attend hospital as an outpatient? ☐ Yes ☐ No

If the patient attended hospital as an outpatient, please specify the dates below:

DATE OF VISIT: dd|mm|yy	DATE OF VISIT: dd|mm|yy
DATE OF VISIT: dd|mm|yy	DATE OF VISIT: dd|mm|yy
DATE OF VISIT: dd|mm|yy	DATE OF VISIT: dd|mm|yy

Does this ward fall into any of the following categories:
a convalescent ward; self-care; a nursing ward; or a ward with rest home facilities? ☐ Yes ☐ No

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:	HOSPITAL/GP ADDRESS OR STAMP:
TITLE:	

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 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	CONSULTANT NAME
ADDRESS	ADDRESS
PHONE NUMBER	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.

Continue overleaf

I also authorise any physician or other person to furnish American International Group 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

For security we will ask them to verify their identity by confirming your date of birth, post code and policy number.

NAME: RELATIONSHIP:

How We Use Personal Information

American International Group 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.

Continue overleaf

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 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: 0208 662 8101