

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 to prevent fraud and money laundering.

We can supply on request further details of the agencies and databases we access or contribute to and how this information may be used. If you require further details please contact us at:

Policy Investigation Unit, Aviva, PO Box 121, Surrey Street, Norwich, NR1 3ZH, Telephone: 0345 300 0597.

Email PIUUKDI@AVIVA.COM

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 provide us with other satisfactory proof of identity;
- Check details of job applicants and employees.

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. When you tell us about an incident we will pass information relating to it to a database.
- We may search these databases when you apply for insurance, in the event of any incident or claim, or at time of renewal to validate your claims history or that of any other person or property likely to be involved in the policy or claim.

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).

You should show these notices to anyone who has an interest in the insurance under the policy.

Telephone Call Charges and Recording

Calls to 0800 numbers from UK landlines and mobiles are free. The cost of calls to 03 prefixed numbers are charged at national call rates (charges may vary dependent on your network provider) and are usually included in inclusive minute plans from landlines and mobiles. For our joint protection telephone calls may be recorded and/or monitored.

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
<input type="text"/>	<input type="text"/>

Claimant Details

Title	First Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of Birth	Email Address
<input type="text"/>	<input type="text"/>

Full Address including postcode

Contact Daytime Telephone No.	Contact Evening Telephone No.
<input type="text"/>	<input type="text"/>

Claimant's Occupation Details

Occupation	Are you self-employed	Date of Employment
<input type="text"/>	yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/>

Full Occupation Address including postcode

Nature of Occupation	How many hours a day do you perform admin duties?
<input type="text"/>	<input type="text"/>

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 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

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:	<input type="text"/>	Time of admission:	<input type="text"/>	AM	<input type="checkbox"/>	PM	<input type="checkbox"/>
Date of discharge:	<input type="text"/>	Time of discharge:	<input type="text"/>	AM	<input type="checkbox"/>	PM	<input type="checkbox"/>

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):

How and why we use your information

We (Aviva), and our third parties, collect and use information (including data about health and unspent offences or criminal convictions) about you and, if relevant, somebody else covered under your policy and your vehicle(s), business and property.

We do this so we can:

- verify your identity and help prevent fraud
- calculate our risk to insure you
- calculate your price
- set up, assess and maintain your insurance contract with us
- renew and make changes to your cover
- process claims
- carry out marketing, profiling and analytics

We share information within the Aviva Group, our reinsurers (our own insurers) and specific other organisations for these purposes.

The information comes from:

- what you've already told us
- data we already hold about you (including from other quotes and policies with us)
- publicly available sources
- other organisations we trust
- data about your device, general location and how you interact with our website

We use automated processes to make decisions

This means our software decides whether we can insure you and on what terms, deal with claims and carry out fraud checks. For more information, see the Privacy Notice for this policy.

You have rights about your information

For more about your rights and how and why we use your data, see the Privacy Notice for this policy. There's more detail in our Privacy Policy at www.aviva.co.uk/privacypolicy or you can request a copy by writing to us at Aviva, Freepost, Mailing Exclusion Team, Unit 5, Wanlip Road Ind Est, Syston, Leicester, LE7 1PD.

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:	<input type="text"/>	Date of Birth:	<input type="text"/>		
Are you the Claimant's usual medical attendant?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If YES, for how long?	<input type="text"/>				
When did the claimant first consult any Doctor for the present injury/illness?				<input type="text"/>	
When was the last time the claimant consulted you?				<input type="text"/>	
Has the current condition been caused by an accident?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

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

Access to your medical information

We need information about your health from your doctor to support or check the details provided to us as part of this claim. This form explains how we obtain your medical information, why we need it, and gives important information about your rights. You'll need to sign it and return it to us. You don't have to do so, but if you don't we may be unable to process this claim or proceed with any benefits for a claim already in existence.

What information we need and why we need it

We need your consent to ask your doctor for a report containing specific medical information about your health, to review your claim and to consider whether your reported injury or illness is covered by your policy.

We do this under the Access to Medical Reports Act 1988 (or if you live in Northern Ireland or the Isle of Man, the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and the Isle of Man Access to Health Records and Reports Act 1993 respectively). This is specific legislation which allows insurers, like Aviva, and our claims processors to, with your consent, obtain a medical report which helps us to review your claim in full.

Once we've got the report, we may need to ask for supplementary records (such as specialist letters or x rays) from your doctor to give us any additional information we need to fully assess your claim.

Please be assured that we'll only ask for, and only take into account, the medical information that we need for the claim you are making. We respect the confidentiality and privacy of your information and will ensure that your medical information isn't kept for longer than is necessary and is safe in our hands.

What you need to know

- By signing this form, you give consent to Aviva, who is the insurer of your policy, to request a medical report from your doctor.
- We'll use this form as proof that you've given your consent to request a medical report from your doctor.
- You can withdraw your consent at any time before your doctor sends the medical report to us. If you do change your mind, we may be unable to process your claim or proceed with benefits for a claim already in existence.
- You can ask your doctor to send a copy of the medical report they are preparing before they send it to us. If you would like them to do this, let us know and we'll tell your doctor so they can keep the report for you. You will then have 21 days to arrange to see it with your doctor's surgery. Your doctor will send it to us, unless you tell us that you are withdrawing consent to access the report.
- You can ask your doctor for a copy of the medical report at any time. They should keep a copy for up to six months after sending it to us. If you would like to see a copy of the report at a later date, we can send them a copy to pass on to you.
- If you think any part of the medical report is incorrect or misleading, you can ask your doctor to amend it. If your doctor refuses, you can ask them to attach a statement outlining your views to the report.
- Your doctor can withhold access to the medical report if they feel it would cause physical or mental harm to you or others.

What types of medical information we ask for

We'll ask your doctor to prepare a medical report containing information about:

- your medical history, including details of any relevant illnesses, trauma, hospital admissions, medical consultations, referrals, tests or investigations and treatments you may have had; and
- your current state of health including any care, medication or treatment you're receiving and the results of any referrals or tests you're waiting for.

We won't ask your doctor to include information about:

- Negative tests for HIV, hepatitis B or C;
- sexually-transmitted diseases – unless there could be long-term effects on your health; or
- predictive genetic test results.

If this information is included in the medical report, we won't take it into account when considering a claim except for:

- genetic tests for Huntington's disease, but only when the total amount of your life cover is more than £500,000.
- favourable genetic test results, if they show that you haven't inherited a condition your family suffers from.

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

YOUR RIGHTS/ACCESS TO MEDICAL REPORTS ACT 1988 (Continued)

More information

If you have any questions about your rights under the Access to Medical Reports Act 1988 or the process of getting, assessing or storing medical information, please write to: Chief Medical Underwriter, Aviva, Wellington Row, York, YO90 1WR.

If you want to know more information generally about how Aviva uses your personal data and your rights in relation to it, please refer to the Data Protection Privacy Notice that you should have received when you applied for the policy or you can view the full Privacy Policy at: www.aviva.co.uk/privacypolicy, or request a copy by contacting Aviva, Freepost, Mailing Exclusion Team, Unit 5, Wanlip Road Ind Est, Syston, Leicester, LE7 1PD.

CONSENT TO OBTAIN A MEDICAL REPORT

By signing this form, I confirm that:

- I am (Full Name)
- I've read this form and am happy to consent to Aviva, seeking a medical report (and, if required, supplementary medical information as part of the report) from my doctor regarding my physical and/or mental health so that you can process this claim.
- I am aware that I may contact you at any time to withdraw the above consent.

SIGNED

DATE

NAME (Please print)

POLICY NO

Aviva Insurance Limited. Registered in Scotland, No. 2116. Registered Office: Pitheavlis, Perth PH2 0NH. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority

Aviva Insurance Ireland Designated Activity Company, trading as Aviva, is regulated by the Central Bank of Ireland.

A private company limited by shares. Registered in Ireland, No. 605769. Registered Office: One Park Place, Hatch Street, Dublin 2, Ireland, D02 E651.

UK Branch Address: St Helen's, 1 Undershaft, London EC3P 3DQ. UK branch deemed authorised by the Prudential Regulation Authority.

Subject to regulation by the Financial Conduct Authority and limited regulation by the Prudential Regulation Authority.