Personal Accident Claim Form

This form should be completed as fully as possible in BLOCK CAPITALS and returned immediately to your Broker with supporting documents.

Please ensure that all relevant questions are answered, and that all appropriate sections and boxes are completed. Failure to do so may delay the processing of your claim.

The form when fully completed must be returned to your Insurance Broker, who arranged this insurance for you. They will forward it to AIUA.

Insurance Broker Details

Name & Address			
Postcode		Tel no.	
Contact name		Email	

If the benefit is to be used for the provision of a replacement worker, please support with evidence of expenditure.

Sections A Insured Person Accident/ Sickness Details) & Section B (Access to Medical Records) to be completed by the Insured. Section C to be completed by the attending medical practitioner.

Section A: Insured Person Accident/Sickness Details (To be completed by the claimant)

If you are unable to complete this form personally, due to your disability, it may be completed on your behalf.

Policy No.		Policyholder Name	
Insured Person's Name			
Date of Birth		Occupation(s)	
Address			
Postcode		Tel no.	Mobile

Please state your average gross weekly wage, calculated over the 12 months prior to the commencement of disability.

If you are claiming for Temporary Total or Temporary Partial Disablement, please provide payslips or copy accounts confirming details of your Gross Weekly wage for the 52-week period prior to the date of the accident or onset of the sickness.

Please state the date from which you have been unable to attend your normal occupation?

Have you ever suffered from this or any connected disability prior to the insurance commencing? ◯ Yes ◯ No

If 'yes' please provide full details, including dates.

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Are you still **totally** incapacitated as a result of your accident/sickness? ◯ Yes ◯ No

If 'no' please provide the date that you were able to undertake

a) Part of your duties

b) All of your duties

ACCIDENT - Date and time of Occurrence

SICKNESS - Date upon which symptoms first appeared

Please describe the circumstances leading to your accident

Please describe the nature of your sickness

Please provide the name and address of the Doctor who attended you.

Please provide the name and address of your usual Doctor (if different).

When did you first seek medical attention in relation to your disability?

During what period have you been confined to hospital? From To

What is your expected date of return to work?

Full name and address of employer at the commencement of disability

Have you previously claimed personal accident/ sickness benefits under this insurance? ◯ Yes ◯ No

If Yes, please provide full details

Are you covered for benefits for your disability under any other insurance? ◯ Yes ◯ No

If Yes, please provide full details

DECLARATION

I/We understand that in handling this claim, AIUA (a trading name of Geo Underwriting Services Ltd) will act on behalf of the Insurer(s) and that **I/We** confirm our informed consent to the claim being handled on this basis. **I/We** understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution. **I/We** confirm that the information given on this form is to the best of my knowledge and belief, true in every respect and that I have declared and not claimed amounts refunded to me or claimed from any other source.

You must read the declaration before signing.

Signed

Date

If you are not the insured person, please state your relationship to them

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SECTION B: Access to Medical Records ACT 1988

In accordance with the Act and before we can apply for a medical report from your doctor, we need your consent. Before signing in the space below, you should know that you have certain rights under the Access to Medical Records Act 1988.

These are set out below:

(A) You can withhold your consent.

(B) You can see the report before it is sent to us or during the six months after that.

(C) You can ask the doctor if he will amend any part of the report, which you consider to be incorrect ormisleading. If the doctor is not in agreement, you may append your comments.

(D) The doctor can withhold from you the report, or part of it, if he/she thinks you would be harmed by seeing it.

CONSENT TO OBTAIN MEDICAL REPORT

Name of Insured Person | Date of Birth

Address:

Post Code

I/We understand that in handling this claim, AIUA (a trading name of Geo Underwriting Services Limited) will act on behalf of the Insurer(s) and that I/We confirm our informed consent to the claim being handled on this basis. I/We understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution.

I/We confirm that the information given on this form is to the best of my knowledge and belief, true in every respect and that I have declared and not claimed amounts refunded to me or claimed from any other source. I have been informed of my statutory rights under the Access to Medical Records Act 1988. In connection with my insurance claim hereby consent to AIUA and/or AXA Insurance Ltd instructed to deal with this claim on their behalf, being provided with medical information from any doctor; who at any time, has attended me

concerning anything which affects my physical or mental health. I agree that a copy of this consent shall have the validity of the original.

You must read the declaration before signing

I wish to see the report before it is sent to the company (please select) ◯ Yes ◯ No

Signed | Date

Name of Doctor

Address:

Post Code

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SECTION C: Medical Report (To be completed by the attending medical practitioner)

The claimant must obtain at his or her own expense the following Certificate from a qualified and Registered Medical Practitioner.

Are you the usual Medical Attendant of the claimant? ◯ Yes ◯ No

If Yes, how long have you been so?

On what date did you first attend upon claimant for his/her present disability?

From what date did you first sign the claimant as unfit for work?

Please confirm the nature of the sickness or injury sustained, together with details of the precise diagnosis and treatment being given

Has the claimant suffered from this or any other associated complaint, prior to this period of disability? ◯ Yes ◯ No

If yes, please give the details and types of treatment.

Date	Treatment

At the time of the accident or commencement of sickness was the claimant suffering from any other sickness or disease? ◯ Yes ◯ No

If 'Yes', please give details with medication prescribed and advise whether this will delay the recovery of this disability

Is the disability caused by or traceable to any gradually developing bodily deterioration? ◯ Yes ◯ No

If Yes, please provide full details including original date of onset

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SECTION C: Medical Report (To be completed by the attending medical practitioner)

Is the disability due to Human Immunodeficiency Virus (HIV) and/or any HIV related sickness, any psychiatric, mental or nervous disorder, mental sickness, anxiety, stress or depression, self inflicted injury, drug abuse, pregnancy or childbirth related conditions?

◯ Yes ◯ No

If Yes, please provide details

When do you expect claimant to return partial duties?

When do you expect claimant to return full duties?

If the claimant has already returned to work please state the date and whether he/she was able to return to all, or just part of his/her duties

DECLARATION BY YOUR DOCTOR

I confirm that that the claimant is/was under medical attention, and was totally prevented from working for remuneration or profit from his/her normal occupation

From To

Doctor's Signature

Doctor's name

Date