ADVENT INSURANCE PCC

ACCIDENT PROTECTION PLAN
CLAIM FORM

Accident Protection Plan

Please return the form to:

By Post:
Claims Department
Union Income Benefit
39/51 Highgate Road
London
NW5 1RT

By Email:
claims@uibuk.com

If you have any queries regarding your cover or require guidance in completing this form then please contact our claims helpline on Telephone: 0800 014 7024 or by Email: claims@uibuk.com
Lines open Mon to Fri 9 a.m. to 6 p.m. Telephone calls may be recorded for monitoring and quality purposes.

Before going ahead with a claim please read your policy and schedule to make sure that you understand your cover and any exclusions.

Claims under your policy will be handled by Union Income Benefit

Completion of Claim Form

In order for us to deal with your claim promptly please complete **Section A** of this form yourself. Please ask the General Practitioner, Hospital Consultant or Doctor attending to complete **Section B** of this form.

Please complete all relevant parts of the form, write in BLOCK CAPITALS and tick any boxes as appropriate. **Please refer to your Policy Schedule for details of cover.**

Please note you will be responsible for any expenses which may be incurred in the completion of this claim form, for more information on this please refer to section 8 of the Policy Wording.

Please ensure that you sign and date the Declaration and Consent at the end of the claim form. Please ensure that you read the Data Protection Notice on p7 and the information relating to the rights under the Access to Medical reports on p8 of this document.

Important Notes

The questions on this form and any other questions which we specifically ask, relate to facts considered to be material to the handling of your claim. Please answer them fully and honestly and supply any additional relevant information. Failure to do so may not only invalidate this claim but also the insurance provided by the policy as a whole.

Checklist

Please return the completed claims form together with any enclosures to Claims Department, Union Income Benefit, 39/51 Highgate Road, LONDON, NW5 1RT, or email to claims@uibuk.com and please ensure:

- ☐ You fully complete every question **before** your doctor completes the Hospital statement
- ☐ You have enclosed all requested original documents (we recommend you retain copies)
- ☐ You have signed this claim form
- ☐ Your attending doctor fully completes the statement
- ☐ All documents that are scanned and sent by email are clear and copied in full

As failure to do so will result in delay in handling your claim.

Section A:1 - Personal details

PLEASE WRITE IN BLACK INK AND USE BLOCK CAPITAL LETTERS. ALL SECTIONS MUST BE COMPLETED OR MARKED 'NOT APPLICABLE'. PLEASE REFER TO YOUR POLICY SCHEDULE FOR DETAILS OF COVER. COMPLETE THE CHECKLIST AND ENSURE THAT YOU SIGN THE DECLARATION AT THE END OF THIS FORM.

Policyholder's details

Policyholder		Policy number
Insured Person forename	Insured Person surname	Insured Person date of birth
Policyholder Address		
		Postcode
Cover type Single ☐ Joint ☐		Email address
Landline Telephone		Mobile Telephone

Injured person's details

To be completed in respect of the person injured
(a separate claim form should be completed for each person wishing to claim)

Full name (if Policyholder state 'as above')	
Address (if different from above)	
	Postcode
Relationship to Policyholder	Email address
Landline Telephone	Mobile Telephone

If not the Policyholder, claimant's details

Full name	
Address	
	Postcode
Relationship to Policyholder	Email address
Landline Telephone	Mobile Telephone

For what is the claim being made: Accidental death ☐ Injury ☐

Only applicable for an accidental death claim: Grant of representation/probate is required.

Please confirm you have enclosed it: Yes ☐ No ☐

Section A:2 - Details of the accident

Location of accident	Date of accident	Time of accident

Please give full details of the nature and severity of the injuries sustained and how the accident occurred indicating what the claimant was doing at the time.

Was the claimant a driver or passenger? Driver ☐ Passenger ☐ Did the Police attend at the time of the accident? Yes ☐ No ☐ If "no" was the accident reported to the Police? Yes ☐ No ☐	Name of the Police Officer and Address of Station involved
Accident reference number	
If a motor accident, is there any prosecution pending for drink-driving? Yes ☐ No ☐	If the accident took place at work, was it noted in the accident book? Yes ☐ No ☐
A:1.2: Name, address and telephone number of the Employer	

If the accident took place overseas: Date claimant left the United Kingdom	Date returned	Purpose of visit
Passport number		Airline used and flight number
If Accident was in a European Economic Area country did you obtain the European Health Insurance (EHIC) card? Yes ☐ No ☐ **If yes, please attach**		
Please give names, address and telephone numbers of witnesses, if any.		

Section A:3 - Medical care

Name, address and telephone number of the claimant's Qualified Medical Practitioner		
Name, address and telephone number of attending Qualified Medical Practitioner if different from above		
Date on which Doctor was first consulted	Date on which the claimant last worked	Did the claimant attend a Casualty Department Yes ☐ No ☐

If "yes" please give name, full postal address and telephone number of hospital attended.	Date attended

Section A:4 - Other insurances

Please give details of any other insurance claims arising from this accident including Motor Insurance.

Name and full address of insurers
Policy numbers

Section B:1 - Medical certificate

(to be completed in all cases by the Qualified Medical Practitioner in attendance)

NB. Any fee is payable by the patient.

This is to certify that the patient named below
suffered the injuries indicated below as the direct result of the Accident stated in **Section A:2** of this Claim Form

Full name of patient			
Patient's date of birth	Accident date	Hospital admission date	Discharge date

Accidental Death Date of death	Death certificate enclosed Yes ☐ No ☐ **(please send a certified copy not the original)**
If no certified copy of death certificate enclosed, please explain why	

Section B:2 - Hospital statement (only to be completed if claiming hospitalisation benefit)

This section must be fully completed by hospital medical staff or records – any fee for completion of this section is the responsibility of the Insured Person

(a) Type of hospital/ward: _____

(b) Name of Doctor or Consultant in charge: _____

(c) The dates admitted and released: ADMITTED: _____ RELEASED: _____

(d) Was any period spent in intensive care: YES / NO FROM: _____ TO: _____

Is there any additional information that you feel is relevant? _____

_____

_____ _____

SIGNED DATE

Position held in Hospital: _____ Qualifications: _____

Please use validation stamp or complete in block capitals:-

Hospital Name: _____

Address: _____

_____

Telephone No: _____

Thank you for your assistance in completing this form.

VALIDATION STAMP

If the injury suffered is not listed please state precisely the nature of the injury	
What date did the patient first seek medical consultation from his Qualified Medical Practitioner for this, or a connected condition?	When was the patient first referred to you in connection with the above condition?
Name and Address of the attended Hospital	
Signature of Qualified Medical Practitioner Date	
Name and Qualifications	
Were the injuries treated solely as a result of the accident described in **Section A:2** of this claim form? Yes ☐ No ☐ **If "no" please give full details**	
Hospital Patient Number	Telephone number
Official Stamp	

Declaration and Consent

I declare to the best of my knowledge and belief all the information given in this form is complete, true and correct.

If the information given on my behalf in **Section B** is inadequate for the purpose of my claim, I consent to Union Income Benefit obtaining a medical report from my Qualified Medical Practitioner relating to the history and nature of the condition and/or its treatment.

I am aware of my rights as detailed on page 8 under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and agree that a copy of this consent shall have the validity of the original.

☐ I do wish to see the medical report before it is sent to Union Income Benefit

☐ I do not wish to see a copy of the medical report before it is sent to Union Income Benefit

Your rights under the Access to Medical Reports Act (1988) and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991

Before giving your consent for us to obtain a medical report, please ensure you read these notes carefully as they set out your rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

- You do not have to give your consent, but if that is the case we may be unable to proceed with the claim.
- If you give your consent, we will inform the Doctor of this at the time we request the medical report.
- You will then have the right to advise the Doctor, in writing, that you wish to see the report before it is sent to us. If you do this, the Doctor cannot send us the report until either:-

  a) you have seen the report and consented in writing to it being sent to us, or

  b) 21 days have passed and you have not asked the Doctor to see the report.
- It is your responsibility to make arrangements with your Doctor to see the report which has been prepared. The quicker you act the quicker we can proceed with your claim.
- Even if you did not originally wish to see the report, you can change your mind. In these circumstances, you must inform both us and the Doctor. You will then have 21 days to contact the Doctor to arrange to see the report.
- Whether or not you ask to see the report which is sent to us, you also have the right to ask your Doctor to let you see a copy, provided that you make your request within the six months after the report was sent to us.
- If you see any report, in accordance with your rights, the Doctor will need your consent before he/she can send it to us.
- If you disagree with the content of the report, you can write to the Doctor asking him/her to amend any part of the report which you consider to be incorrect or misleading.
- If you and your Doctor cannot agree on the facts set out in the report, you have the right to ask him/her to attach a statement of your views on any part of the report which you disagree with and which the Doctor is not prepared to alter.
- The Doctor is not obliged to let you see any part of the report if:-

  a) in his/her opinion, it would be likely to cause serious harm to your physical or mental health or that of others, or

  b) it would indicate the Doctors intentions in respect of you, or

  c) 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 to, or the information relates to, or has been supplied by, a health professional involved in caring for you.

  In such cases, the Doctor must notify you accordingly and you will be able to see only the remainder of the report. If the whole report is affected, he/she must not send it to us unless you give your consent.
- We will pay for the original report but if you ask for a copy, the Doctor can charge a reasonable fee to cover the cost of supplying it.

To be signed by the Policyholder or in the event of an Accidental Death claim for the Policyholder this should be signed by the Policyholder's legal representative.

	Date

To be signed by the injured person if other than the Policyholder.

	Date

Please return this form by email: claims@uibuk.com
Or by post: Claims Department, Union Income Benefit,
39/51 Highgate Road, London, NW5 1RT

Section C - Data Protection Act 2018 Consent Form

You may wish for a family member or your legal representative to be given access to your personal and medical information in order to help you with your claim.

In order for us to be able to discuss your claim with anyone other than yourself or our appointed agents we need your specific written permission. Please note that this consent would not allow anyone other than yourself to receive any benefit payments.

You may activate or cancel your permission at any stage throughout your claim. Please contact us should you wish to make any changes.

Certificate number or Policy number	
Do you wish for your personal information to be given out to a family member or legal representative? Yes ☐ No ☐	
If **YES** then please complete the following section:	
The name of your appointed family member or legal representative	
Their relationship to you	Their date of birth
Their contact address	
Postcode	

Claim Form Declaration

DATA PROTECTION ACT 2018 I hereby consent to any information you have about me being processed by you for the purposes of providing insurance and claims handling, which may necessitate your providing such information to third parties.

AND

I hereby declare that the statements in this claim form are true in every respect to the best of my knowledge and belief and that I have disclosed all information likely to influence the assessment of my claim. I consent to the seeking of information from my present employer and any doctor who has treated me or any person/organisation that is deemed necessary, to check the answers have provided, and I authorise the giving of such information. A copy of this authorisation shall be considered as effective and valid as the original. I understand and agree that information regarding my claim may be shared with other insurers, loss adjustors and the Benefits Agency for fraud prevention purposes and that I consent to my claim being investigated as part of this process.

Signed

Date

Data Protection Notice

The Personal Information **you** provide

Advent Insurance PCC Ltd (UIB Cell) and Union Income Benefit Holdings Ltd, the **administrator**, are the joint data controllers (as defined in the Data Protection Act 2018 (DPA)) and fully accept the responsibility of protecting the privacy of customers and the confidentiality and security of personal information provided to either party. In this notice, Personal Information is personal data (as defined in the DPA) and means any information that identifies an individual and includes any sensitive personal information (e.g. information about health or medical condition(s)).

Where this notice refers to **you** or **your** Personal Information, this will include any information that identifies another person whose information **you** have provided to **us** or the **administrator**. **We** and the **administrator** will assume that they have appointed **you** to act for them). **You** agree to receive on their behalf any data protection notices from **us** or the **administrator**.

Your Personal Information will be used for the purpose of providing insurance services. By providing Personal Information, **you** consent that **your** Personal Information, will be used by **us**, the **administrator**, our reinsurers, service providers/ business partners, and **our** agents for administration, customer service, claims handling, assistance services, customer profiling, and for management and audit of **our** business operations. **We** or the **administrator** may also pass **your** Personal Information to other insurers and regulatory and law enforcement bodies for the prevention of fraud, financial crime or where the law requires **us** or the **administrator** to do so.

We or the **administrator** may transfer **your** Personal Information to countries outside the EEA which may not have the same level of data protection as in the United Kingdom and Malta, but if this is necessary it will be ensured that appropriate safeguards are in place to protect **your** Personal Information. If **you** ask **us** or the **administrator**, what Personal Information is held about **you** it will be provided to **you** in accordance with applicable law. No fee will be charged for this. Any Personal Information which is found to be incorrect will be corrected promptly. **You** have the right to withdraw **your** consent to **us** or the **administrator** processing any of **your** Personal Information at any time, if it is not specifically required for **us** or the **administrator** to provide and administer the product or service that **you** have purchased or registered for. **We** and the **administrator** may monitor and/ or record **your** communication with **us** or the **administrator**, either ourselves or using reputableorganisations selected by **us**, to ensure consistent servicing levels and account operation. **We** or the **administrator** will keep information about **you** only for so long as it is appropriate.

We will not use **your** Personal Information in order to provide **you** with marketing unless **you** have given **your** explicit constent to allow **us** to use this information for this purpose. If **you** wish to unsubscribe from our marketing communications please contact **us** on the details below quoting **your** name, address, telephone number and email address. **You** have the right to ask **us** to delete **your** data or cease processing it at any time, however we may not be able to do this if we require **your** data in respect of our contract with **you**.

We have a dedicated Data Protection Officer who **you** can contact for any queries or to exercise any of **your** rights under data protection regulations including: data subject access requests, correcting **your** information, making a complaint. If **you** believe we are holding inaccurate information about **you** or wish to request a copy of **your** information, **you** should contact **us**.

Contact Details:

Union Income Benefit, Data Protection Officer

By email: dataprotection@embignell.com

By post: Data Protection Team, Embignell Ltd. Unit A, Piano Yard, Highgate Road, London NW5 1BF

We will provide the information that **you** have requested in a suitable format to meet **your** requirements. If we cannot resolve the complaint to **your** satisfaction, **you** can contact the Information Commissioner's Office who are the Supervisory Authority in the UK protecting the rights of individuals under current Data Protection regulations.

Website: www.ico.org.uk

By telephone: 0303 123 1113