



# ACCIDENT PROTECTION PLAN CLAIM FORM

**Accident Protection Plan  
Claims Department  
Compass Underwriting Ltd  
50 Mark Lane  
London EC3R 7QR**

**claims@compassuw.co.uk**

**0800 319 6601**

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

Name of Policyholder	Certificate/Policy no.	
Insured Person forename(s) (Mr/Mrs/Miss/Ms)	Insured Person surname	
Full address		
	Postcode	Date of birth
Telephone no. work	Telephone no. home	
Email address		

## Checklist

Please return the completed claims form together with any enclosures to Claims Department, Compass Underwriting Ltd., 50 Mark Lane, London EC3R 7QR, or email to [claims@compassuw.co.uk](mailto:claims@compassuw.co.uk) 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.

## Accident details

Please give exact date and time when injured: DATE \_\_\_\_\_ TIME \_\_\_\_\_ am/pm

Please state fully:-

(a) Where the accident occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(b) How the accident occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(c) The injuries sustained: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you previously claimed under this is a similar policy? YES / NO

If YES, please give details: \_\_\_\_\_

\_\_\_\_\_

Please give the name, address and policy number of any other insurance that **may** cover this injury: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 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

Position held in Hospital: \_\_\_\_\_

**Please use validation stamp or complete in block capitals:-**

Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No: \_\_\_\_\_

DATE

Qualifications: \_\_\_\_\_

VALIDATION STAMP

Thank you for your assistance in completing this form.

## Access to Medical Records Act 1988

Before your attending doctor can give you a medical report on this claim form which is a requirement of this claim, you must give your consent. Before giving your consent, you should be aware of your rights under the act which are summarised as follows:-

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of this report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the Doctor to amend any part of the report which you consider to be incorrect or misleading. If the Doctor does not agree with your request you may attach your comments to the report.

NB: The Doctor may withhold all or part of the report from you if he or she considers that you may be physically or mentally harmed by it.

### PATIENT DECLARATION

Having been made aware of my statutory rights under the Access to Medical Records Act 1988 in connection with my claim

1. I hereby consent to Advent seeking medical information from any Doctor who at any time has attended me concerning conditions which affect my physical or mental health.
2.  I **DO** wish to see the report before it is sent to Advent  
 I **DO NOT** wish to see the report before it is sent to Advent
3. I authorise such Doctor to disclose such information to Advent
4. I agree that a copy of this consent shall have the validity of the original

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE

## Payee's bank details

If we approve your claim, we can credit the money directly 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: \_\_\_\_\_

Bank sort code:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Address: \_\_\_\_\_

Account number: \_\_\_\_\_

Name of account holder(s): \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

## Data Protection

The information that you and your medical representative have provided in the claim form and Doctor's Statement is 'sensitive data' as defined by the Data Protection Act 1998. Sensitive data includes any information about your physical and mental health. We require your consent before we can process this or any other such sensitive data that you may have already provided us with or may do so in the future. In order to administer your claim, this information will be used by Compass Underwriting Ltd and Advent Insurance PCC Ltd. It may be held on computer and or in manual files for administration, and risk assessment purposes. We may disclose your personal data and sensitive data to, and may request information from other insurance companies for underwriting, claims handling and fraud prevention purposes. By returning this form, you consent to our processing your sensitive personal data for the above purposes. You also consent to our transferring your information to countries which do not provide the same level of data protection as the UK, if necessary for the above purposes. If we do make such a transfer we will, if appropriate put a contract in place to ensure your information is protected. Where you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

## Declaration

I declare that all the information given is to the best of my knowledge and belief, true and correct.

\_\_\_\_\_  
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 1998 and any successor regulation (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 and the administrator will not share your Personal Information unless you or your nominated personal representative have provided explicit consent or we or the administrator are required to do so by law. 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.

We and the administrator may monitor and/ or record your communication with us or the administrator, either ourselves or using reputable organisations 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 details in order to provide you with marketing, discounts or pricing unless you have given your explicit consent to allow us to use this information for these purposes. 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 Personal Information or cease processing it at any time, however we may not be able to do this if we require your Personal Information in respect of our contract with you.

We have a dedicated Data Protection Officer who you can contact for any queries relating to this policy, 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.

Union Income Benefit Holdings Ltd is a group company of Embignell Ltd.

Contact Details:

Data Protection Officer: Shona Mountford

By email: [dataprotection@embignell.com](mailto: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 the administrator 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: <https://ico.org.uk>

By telephone: 0303 123 1113

## 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](mailto:claims@uibuk.com)  
Or by post: Compass Underwriting Limited,  
50 Mark Lane, London EC3R 7QR**