Aon UK Limited
Aon Underwriting Managers

Report Form for Personal Accident and Sickness Claim

This file is a fillable electronic pdf form. Please complete all questions – if any question is not applicable please state "N/A".

Insured Details

Name of Policyholder

If a subsidiary of the policyholder please provide company name

Policy Number

Relationship to Policyholder Director ◯ Employee ◯ Student ◯ Contractor ◯ Volunteer ◯ Consultant ◯ Other ◯

If Other – *Please provide details*

Full Name of Insured Person

Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Date of Birth d d / m m / y y y y

Insured Person's Full Address

Street

City County

Country Postcode

Email Tel Fax

For security purposes please provide a password which will be required to access your claims information

Employment Details

Occupation/Duties

Name and Address of Employer

Name

Street

City County

Country Postcode

Please provide evidence of annual salary Gross Net

Accident/Sickness Details

Please give exact date and time when injured or taken ill Date d d / m m / y y y y Time

Please state

a The date you ceased working d d / m m / y y y y

b The date you returned to work d d / m m / y y y y

c If you have not returned to work, on which date do you hope to do so? d d / m m / y y y y

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If accident, please state fully

a Where the accident occurred

b How the accident occurred

c The injuries sustained

If illness, please state full details of your illness

Have you ever suffered from this illness before? If Yes, please give details Yes ◯ No ◯

Have you previously claimed under this or a similar policy? If Yes, please give details Yes ◯ No ◯

Please use the space below for any supplementary information

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Doctor's Statement – this section must be fully completed by attending doctor

Any fee for completion of this section is the responsibility of the Insured Person

Patient's Name | Mr ◯ Mrs ◯ Miss ◯ Ms ◯

Date of Birth d d / m m / y y y y | Height | Weight

Please give details of injury/illness

Final Diagnosis

When did the patient first receive medical attention for this condition? d d / m m / y y y y

Has the patient ever suffered with this or any similar condition before the present episode? Yes ◯ No ◯

If Yes, please give details including dates of treatment and consultation

Are you the patient's usual doctor? Yes ◯ No ◯

If No, please give name and address of usual doctor

Name

Street

City | County

Country | Postcode

On what date did incapacity commence? d d / m m / y y y y

Is patient still incapacitated? Yes ◯ No ◯

If Yes, when will patient be able to return to work? d d / m m / y y y y | If No, when did incapacity cease? d d / m m / y y y y

Was the patient hospitalised as a result of this condition? Yes ◯ No ◯

If Yes, please state dates of hospitalisation? Admitted d d / m m / y y y y | Discharged d d / m m / y y y y

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Is there any additional information that you feel is relevant?

Signed

Date d d / m m / y y y y

Qualifications

Please use validation stamp or complete in block capitals

Name

Address

Telephone

Doctor's Validation Stamp

Thank you for your assistance in completing this form.

Access to Medical Reports 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 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 it is considered 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 Reports Act 1988 in connection with my claim:

1 I hereby consent to Insurers or their representative 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 Insurers or their representative. ○

I DO NOT wish to see the report before it is sent to Insurers or their representative. ○

3 I authorise such doctor to disclose such information to Insurers or their representative.

4 I agree that a copy of this consent shall have the validity of the original.

Signed

Date d d / m m / y y y y

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Data Protection

In order to administer your claim, this information will be used by Chubb European Group Limited and Aon UK Limited. 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 reinsurers, the policyholder and the AuMine Claims Database, 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 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.

Conflicts of Interest

Please note: Aon Underwriting Managers (AUM) is a Managing General Agent which is part of Aon UK Limited and is authorised by the Insurer to handle claims under the AonProtect scheme and will do so under the terms and conditions of the policy. Aon Underwriting Managers are therefore acting for the insurer. Any objection to this arrangement should be raised when first reporting the claim.

Declaration

By signing/inputting my name below and submitting this form I consent to the above data protection disclosure and I declare that all information given is to the best of my knowledge and belief, full, true, accurate and correct. **Please print and sign.**

Print Name	**Signed**	**Date**
		d d / m m / y y y y

Documents Required

Medical Certificate — Enclosed ◯ To follow ◯

Please Ensure

1. You have completed ALL relevant questions on the claim form.
2. You have enclosed all requested information/documentation.
3. You have signed this claim form.
4. The attending doctor has fully completed the doctor's statement.

Failure to do so will result in a delay in handling your claim.

Thank you for completing this form.

IMPORTANT

Please print and sign this form and return to:

Aon Underwriting Managers | Claims
Grosvenor House
65–71 London Rd
Redhill
Surrey
RH1 1LQ

t +44 (0)1737 783 740 | f +44 (0)1737 783 741

Or scan and email to: **aum.claims@aon.co.uk**

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