Aon UK Limited
Aon Underwriting Managers

AonProtect Academia Report Form for Medical Expenses for Offsite Activities

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 Group Policyholder (Council)

Name of School

Policy Number

Relationship to Policyholder Teaching/Support Staff ◯ Student ◯ Volunteer ◯ 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

Full Name of Claimants

Date of Birth d d / m m / y y y y Relationship to the Insured Person eg, Partner, Son, Daughter

Date of Birth d d / m m / y y y y Relationship to the Insured Person eg, Partner, Son, Daughter

Date of Birth d d / m m / y y y y Relationship to the Insured Person eg, Partner, Son, Daughter

Accident/Sickness Details

Type of Travel Offsite Activity ◯ School Trip ◯ Date of Trip d d / m m / y y y y

Please give exact date and place when injured or taken ill Date d d / m m / y y y y Place

Did you contact AonProtect Emergency Assistance? Yes ◯ No ◯

If Yes, please provide AonProtect Emergency Assistance reference number

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If No, please provide an explanation why AonProtect Emergency Assistance was not contacted

Was a European Health Insurance Card (EHIC) used? Yes ◯ No ◯

If No, please provide an explanation why the EHIC was not used

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/the claimant ever suffered from this illness before? If Yes, please give details with relevant dates Yes ◯ No ◯

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Please state whether you/the claimant were in hospital? 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

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

Please give name and address of General Practitioner in the UK

Name

Street

City County

Country Postcode

Details of Expenses

All accounts, bills, receipts, medical certificates, booking invoices, any correspondence and any other documents relative to this claim should be forwarded to the company

Claimant Name	Nature of Expense	Name and Address of Doctor or Hospital Attended	Currency being claimed	Amount	Paid

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Claimant Name	Nature of Expense	Name and Address of Doctor or Hospital Attended	Currency being claimed	Amount	Paid
			Total		

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

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.

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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

Payee Advices

All claims payments will be issued payable to the policyholder (your employer/company) and not the claimant unless Aon Claims has received prior authorisation to pay the claimant direct.

However, if you are the claimant and require any payment to be made to yourself, your Company Insurance Administrator or Line Manager will need to provide written/emailed authorisation to Aon Claims.

Bank Details

When the claim has been approved and once we have received written confirmation from the policyholder to issue any payments due direct to the claimant, you may have the payment credited direct to your bank account. This payment method is both speedier and safer than payment by cheque. If you would like to take advantage of this arrangement, please complete the following:

Bank name ______ Sort Code ______ Swift Code ______

IBAN Code ______

Bank Address ______

Account Name ______

Account Number ______

Documents Required

Original travel documents (*these can be returned to you where necessary*)	Enclosed ○	To follow ○
ALL original medical bills	Enclosed ○	To follow ○
Cancellation invoice	Enclosed ○	To follow ○
If appropriate, a medical report from your usual Doctor, or Dentist in the case of dental treatment	Enclosed ○	To follow ○
Itinerary	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.

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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