



Personal Accident Insurance Claim Form

GUIDANCE NOTES

PLEASE READ THESE NOTES PRIOR TO FILLING OUT THE FORM OVERLEAF

PAX provides benefits for a whole range of permanent disabilities as a result of accidental bodily injury occurring within the time that your Policy is effective. The degree of any permanent disability may not become certain until a later date. It is important to keep us informed of your progress if there is a possibility that your accident results in even a minor permanent disability.

In addition to benefits for permanent disability, the PAX Personal Accident Plan provides cover for accidental death, specified burns, fractures and hospitalisation (after the first 5 nights continuous stay). This form is to be used for these claims.

The PAX Personal Accident Plan also includes cover for Personal Liability and Legal Protection Expenses. If your claim relates to these please complete a separate claim form which can be requested by contacting PAX Customer Service on 0800 212 480 (within the UK) or +44 20 8662 8126 (from overseas).

If you have selected the Optional Life insurance extension, a separate claim form needs to be completed and can be requested by contacting PAX Customer Service on 0800 212 480 (within the UK) or +44 20 8662 8126 (from overseas). This provides cover for death from natural causes and payments in the event of a confirmed diagnosis of a terminal or critical illness.

Correct completion of claim forms will assist us in handling your claim as quickly as possible. Early notification of all claims is essential.

Section 1 PERSONAL INFORMATION AND ACCIDENT DETAILS

To be completed by the injured person. This may be completed on your behalf if you are unable to do so or if the injured person is a child. This section must be completed for all claims.

Section 2 ACCIDENTAL DEATH CLAIMS

This section must be completed in addition to Section 1 in the event of a claim for accidental death.

Section 3 DECLARATION AND VERIFICATION OF COVER

This section must be completed by the injured person, or someone on behalf of the injured person, for all claims.

Section 4 MEDICAL CERTIFICATE

This must be completed by the attending doctor or specialist for all accident claims.

Section 5 CONSENT TO OBTAIN A MEDICAL REPORT

This must be completed by the claimant for all claims.

Please return the completed form along with any supporting documents to:

From within the UK only
PAX Claims Centre
FREEPOST SEA4075
CROYDON
CR9 1WZ
Email: aigdirect.claims@aig.com

From overseas
AIG Claims Centre
The AIG Building
2-8 Altyre Road
CROYDON
CR9 2LG

THE ISSUE OF THIS FORM DOES NOT CONSTITUTE AN ADMISSION OF LIABILITY UNDER THE POLICY

American International Group UK Limited, PAX Claims Department, The AIG Building, 2-8 Altyre Road, Croydon CR9 2LG

Section 1: Personal information and accident details

Personal information and accident details – to be completed by the injured person. This may be filled out on your behalf if you are unable to do so or if the injured person is a child. This must be completed in full for all claims.

Personal details

The PAX coverholder _____ Service number _____

Full name of injured person _____ Occupation _____

Relationship to the PAX coverholder _____

Address of injured person _____

_____ Postcode _____

Email address _____ Telephone _____

Date of Birth ____ / ____ / ____

Name of person submitting the claim if not the PAX coverholder _____

Address _____

_____ Postcode _____

Email address _____ Telephone _____

Accident details

Was the injured person on duty at the time of the accident? Yes No

Date of accident ____ / ____ / ____ Time ____ am/pm Place _____

How did the accident occur? _____

State, as fully as possible, what injuries were sustained _____

Witness – name and address _____

Length of time confined to hospital? From _____ to _____

Name and address of hospital _____

Name and address of any other hospitals where you were confined (if applicable) _____

Name and address of usual GP/MO _____

Has any other doctor/specialist been consulted? Yes No

If YES, who _____

In the event that benefit is due, please confirm if you require a cheque or bank transfer.

For bank transfer please confirm the following (as this appears in your cheque book)

Account Payee (of claimant unless minor) _____

Account Number _____

Sort code _____

Bank name and postal address _____

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Section 2: Accidental death claims only

Please attach the following two documents with this claim form, or forward them as soon as they become available.

- (a) Death Certificate
- (b) Grant of Probate or Letters of Administration

If they are not available at this time, do not delay sending in the claim form but forward the documents as soon as they become available. Please note that in the event of a valid claim, the benefit can only be paid to the **legal representative** or **Executor**. **You cannot assign (transfer) this insurance to anyone else.**

Section 3: Verification of cover and declaration

We will need to verify that the injured person was covered at the time of the accident. Please attach a copy of the PAX coverholder's payslip showing the premium deduction for the month in which the accident occurred. If you are unable to do so, please do not delay sending this claim form and tell us why below.

In addition, we may need to contact the Administration/Personnel Officer to confirm cover. Please confirm their details below.

Name _____

Address _____

Contact phone no. (if known) _____

Declaration

I hereby declare that the foregoing particulars and any other supplementary statements forming part of this claim are true in every respect.

Please PRINT name of person signing this form _____

Signature _____ Date ____ / ____ / ____

Section 4: Medical certificate

Please ask your attending doctor or specialist to complete this form. Any fee payable for its completion is the responsibility of the claimant and not American International Group UK Limited.

The medical certificate must be completed for all accident claims.

What injuries were sustained as a result of the accident? _____

Date of first referral ____ / ____ / ____ Date ____ / ____ / ____

Has the claimant previously suffered from this or any related condition? YES / NO

If 'YES', please provide details, including the dates of treatment and the outcome _____

During what period has the claimant been confined to hospital? From _____ to _____

What was the name of the hospital? _____

Please confirm the type of ward the patient was admitted to: Orthopaedic Rehabilitation
Convalescence/Extended Care General

Is the claimant still receiving, or recovering from, treatment? If yes, when is the claimant likely to complete the treatment or recovery?

Do you think that the patient will be left with a permanent disability? YES / NO

Name (in capitals) _____

Qualifications (incl. GMC No) _____

Signed _____ Date ____ / ____ / ____

Contact address _____

Postcode _____

Telephone _____

Fax or email address _____

Practice stamp

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Section 5: Access to Medical Records / Medical Reports Consent Form – to be completed by the claimant

Access to Medical Reports Act (1988), Access to Personal Files and Medical Reports (Northern Ireland) Order 1991, Access to Health Records and Reports Act 1993 (Isle of Man) (“Acts”)

To enable American International Group UK Limited or their agents (the Company) to assess your claim, it may be necessary to obtain medical evidence. Any medical reports which are requested from your Doctor (your GP, medical specialists) are subject to the Acts. (Please note that medical reports requested from Doctors appointed by the Company are not subject to the Acts).

In summary your statutory rights under the Acts are as follows:

1. A medical report cannot be requested from any Doctor, who has attended you, without your written authority (consent).
2. You may withhold your consent. However, without your consent we may be unable to proceed with your claim.
3. If you do consent you can indicate whether you wish to see the report before it is supplied to us.
 - a) If you wish to see the report, we will notify your Doctor accordingly. We will advise you that we have done so (notification).
 - b) You will then have 21 days from the date of the notification to contact the Doctor, in writing, to make arrangements to see the report.
 - c) The Doctor will allow 21 days for you to see the report before it is supplied to us.
 - d) If the Doctor has not heard from you within 21 days of the notification he/she will assume you do not wish to see the report and that you consent to it being supplied.
4. If you do not indicate that you wish to see the report, we do not have to notify you if we apply for such report.
5. When you see the report, if there is anything in it that you consider incorrect or misleading you can request, in writing, that the Doctor amends the report, but the Doctor is not obliged to do so. If the Doctor refuses to amend the report you may: (a) withdraw consent for the report to be issued, (b) ask the Doctor to attach to the report a statement setting out your own views, (c) agree to the report being issued unchanged.
6. Whether or not you wish to see the report before it is sent to us, you may ask your Doctor to show you a copy of the report. Please note that the Doctor is obliged to retain the report for at least 6 months after it was supplied. The Doctor may charge a reasonable fee for the cost of supplying the report but not exceeding £50.
7. The Doctor is not obliged to show you any parts of the report that he/she believes might cause serious harm to your physical or mental health or that of others, or it would indicate the Doctor's intentions towards you. If this is the case, the Doctor will tell you if your access to the report is limited

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Section 5: Access to Medical Records / Medical Reports Consent Form – to be completed by the claimant Continued

Please confirm the full name and postal address of your Doctor

Name of GP/MO _____

Address _____

Phone Number _____

Consultant Name _____

Address _____

Phone Number _____

I have read my statutory rights under the Acts as outlined above and **by signing this form** I consent to the Company seeking medical information, including copies of my medical records, from any Doctor who at any time has attended me, concerning anything which affects my physical or mental health relating to the condition (s) that gives rise to my claim.

I also authorise any physician or other person to furnish American International Group UK Limited or their agents with any and all information with respect to any illness, sickness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records relating to the condition(s) that gives rise to my claim. I hereby authorise The Institute of Naval Medicine, the Army Personnel Centre and the RAF Personnel Management Agency to furnish American International Group UK Limited or its authorised representative with any and all information with respect to any illness, sickness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records.

Do you wish to see the report before it is sent AIG? Yes No

Signed _____

Full Name _____

Date ____/____/____

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Section 6: Consent Form

HOW WE USE PERSONAL INFORMATION

American International Group UK Limited is committed to protecting the privacy of customers, claimants and other business contacts.

“**Personal Information**” identifies and relates to you or other individuals (e.g. your partner or other members of your family). If you provide Personal Information about another individual, you must (unless we agree otherwise) inform the individual about the content of this notice and our Privacy Policy and obtain their permission (where possible) for sharing of their Personal Information with us.

The types of Personal Information we may collect and why – Depending on our relationship with you, Personal Information collected may include: contact information, financial information and account details, credit reference and scoring information, sensitive information about health or medical conditions (collected with your consent where required by applicable law) as well as other Personal Information provided by you or that we obtain in connection with our relationship with you. Personal Information may be used for the following purposes:

- Insurance administration, e.g. communications, claims processing and payment
- Make assessments and decisions about the provision and terms of insurance and settlement of claims
- Assistance and advice on medical and travel matters
- Management of our business operations and IT infrastructure
- Prevention, detection and investigation of crime, e.g. fraud and money laundering
- Establishment and defence of legal rights
- Legal and regulatory compliance (including compliance with laws and regulations outside your country of residence)
- Monitoring and recording of telephone calls for quality, training and security purposes
- Marketing, market research and analysis

Sharing of Personal Information - For the above purposes Personal Information may be shared with our group companies and third parties (such as brokers and other insurance distribution parties, insurers and reinsurers, credit reference agencies, healthcare professionals and other service providers). Personal Information will be shared with other third parties (including government authorities) if required by laws or regulations. Personal Information (including details of injuries) may be recorded on claims registers shared with other insurers. We are required to register all third party claims for compensation relating to bodily injury to workers' compensation boards. We may search these registers to prevent, detect and investigate fraud or to validate your claims history or that of any other person or property likely to be involved in the policy or claim. Personal Information may be shared with prospective purchasers and purchasers, and transferred upon a sale of our company or transfer of business assets.

International transfer - Due to the global nature of our business, Personal Information may be transferred to parties located in other countries (including the United States) which may have a data protection regime which is different to that in your country of residence. When making these transfers, we will take steps to ensure that your Personal Information is adequately protected and transferred in accordance with the requirements of data protection law. In AIG's full Privacy Policy (<https://www.aig.co.uk/privacy-policy>), the section “Where do we process Personal Information?” does not apply to Personal Information relating to PAX insured persons provided to us by the Ministry of Defence (Primary Information).

Security of Personal Information – Appropriate technical and physical security measures are used to keep your Personal Information safe and secure. When we provide Personal Information to a third party (including our service providers) or engage a third party to collect Personal Information on our behalf, the third party will be selected carefully and required to use appropriate security measures.

Section 6: Consent Form Continued

Your rights – You have a number of rights under data protection law in connection with our use of Personal Information. These rights may only apply in certain circumstances and are subject to certain exemptions. These rights may include a right to access Personal Information, a right to correct inaccurate data, a right to erase data or suspend our use of data. These rights may also include a right to transfer your data to another organisation, a right to object to our use of your Personal Information, a right to request that certain automated decisions we make have human involvement, a right to withdraw consent and a right to complain to the data protection regulator. Further information about your rights and how you may exercise them is set out in full in our Privacy Policy (see below).

Privacy Policy - More details about your rights and how we collect, use and disclose your Personal Information can be found in our full Privacy Policy at: <https://www.aig.co.uk/privacy-policy> or you may request a copy by writing to: Data Protection Officer, American International Group UK Limited, The AIG Building, 58 Fenchurch Street, London EC3M 4AB.or by email at: dataprotectionofficer.uk@aig.com.

DECLARATION

BY SIGNING THIS FORM I/WE DECLARE THAT THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT A FALSE DECLARATION MAY INVALIDATE MY CLAIM AND COULD RESULT IN PROSECUTION

Print Name _____

Signature _____ Date ____/____/____

Data Protection Consent (sharing Sensitive Personal Information with your employer)

By signing below, I give consent to American International Group UK Limited to sharing Sensitive Personal Information about my health with my employer for reporting purposes.

Print Name: _____

Signature: _____ Date: ____/____/____