

Personal Accident Claim Form



U·M·ASSOCIATION LTD

THANK YOU FOR NOTIFYING US OF YOUR CLAIM
PLEASE COMPLETE ALL QUESTIONS - IF ANY QUESTION IS NOT APPLICABLE PLEASE
STATE "N/A"

Name of Institution (University, College etc):
Certificate No:
Date on which Travel commenced (for incidents occurring during a covered Journey):

Full Name of Person Covered: (Mr., Mrs., Miss, Ms)	Date of Birth:
Full Address:	Postcode:
Tel No. (Business): Email:	(Home):

EMPLOYMENT DETAILS	
Occupation/Duties:	
Name and Address of Employer:	
Please state average annual gross and net salary for 12 months prior to date of accident (please ensure you enclose a copy of the most recent payslip) or over the previous 36 months from the date of accident if self employed (please provide evidence of income by means of Inland Revenue Tax Assessment Forms).	
Gross:	Net:

PLEASE ENSURE YOU SIGN THE DECLARATION ON THIS CLAIM FORM

ACCIDENT DETAILS

Please give exact date and time when injured: Date: Time: am/pm

Please state: (a) The date the Person Covered ceased working:
(b) The date the Person Covered returned to work:
(c) If the Person Covered has not returned to work, on which date does he/she hope to do so?

Please state fully:

(a) Where the accident occurred: _____

(b) How the accident occurred: _____

(c) The injuries sustained: _____

Has the Person Covered previously claimed under this or 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 or illness:

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 RESPONSIBILITY OF THE PERSON COVERED.

- 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:
e) Was the patient subsequently confined to their home on medical grounds? YES/NO
If YES, please give dates: From: To:

Is there any additional information, which you feel is relevant?

Signed: Position held in Hospital:

Date: Qualifications:

Please use validation stamp or complete in block capitals:

Hospital Name: Validation Stamp

Address:

Telephone No:

Thank you for your assistance in completing this form.

DOCTOR'S STATEMENT - THIS SECTION MUST BE FULLY COMPLETED BY ATTENDING DOCTOR. ANY FEE FOR CPMPLETION IS THE RESPONSIBILITY OF THE PERSON COVERED.

Patient's Name: (Mr. ,Mrs., Miss, Ms)

Date of Birth:

Height:

Weight:

Please give full details of injury:

Final diagnosis:

When did the patient first receive medical attention for this condition?

Has the patient ever suffered with this or any similar condition before the present episode?
If YES, please give details including dates of treatment and consultation:

YES/NO

Are you the patient's usual doctor?

YES/NO

If NO, please give name and address of usual doctor:

On what date did incapacity commence:

Is the patient still incapacitated?

YES/NO

If YES, when will the patient be able to return to work?

If NO, when did incapacity cease?

Was the patient hospitalised as a result of this condition?

YES/NO

Is there any additional information which you feel is relevant?

Signed:

Date:

Qualifications:

Please use validation stamp or complete in block capitals:

Name:

Validation stamp

Address:

Telephone No:

Thank you for your assistance in completing this form.

DECLARATION

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

Signed: _____ Date: _____

ACCESS TO MEDICAL REPORTS ACT 1988

Before a doctor can give a medical report on this claim form, which is a requirement of this claim, the Person Covered must give their consent. Before giving consent, they should be aware of their rights under the Act which are summarised as follows:

PATIENT DECLARATION

1. They may withhold their consent.
2. They may see the report before it is sent to us within 21 days From the date of this report.
3. They may ask to see the report for up to six months after the report is completed.
4. They may ask the doctor to amend any part of the report, which they consider to be incorrect or misleading. If the doctor does not agree with this request the Person Covered may attach their comments to this report.

NB The doctor may withhold all or part of this report from the Person Covered if he considers that they may be physically or mentally harmed by it.

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 UMAL seeking medical information from any doctor who at the 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 UMAL
 I **DO NOT** wish to see the report before it is sent to UMAL
3. I authorise such doctor to disclose such information to UMAL
4. I agree that a copy of this consent shall have the validity of the original.
5. I agree that any information obtained by UMAL may also be shared, in confidence, with Arch Insurance Company (Europe) Ltd.

Signed: _____ Date: _____

PLEASE ENSURE

(✓)

- You have completed ALL relevant questions on this claim form.
- You have enclosed all requested information/documentation.
- You have signed this claim form.

As failure to do so will result in delay in handling you claim.
Please return the completed claim form together with any enclosures to

U M Association Ltd., Woburn house, 20 Tavistock Square, London WC1H 9HW.