U M Association Limited

Group Personal Accident Claim Form

Thank you for notifying us of your claim
Please complete all questions – if any question is not applicable please state 'N/A'

Please send the completed form together with all relevant correspondence to:
U M Association Ltd, 5 St Helen's Place, London EC3A 6AB
Telephone: 020 7847 8670 Fax: 020 7847 8689 Email: claims@umal.co.uk

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 including postcode

Telephone no.

Email

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 the last page of 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?

Signature

Date

Position held in hospital

Qualifications

Please use validation stamp or complete in block capitals:

Hospital name

Address

Telephone no.

Validation Stamp

Thank you for your assistance in completing this form

Doctor's Statement

This section must be fully completed by attending doctor. Any fee for completion 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? 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

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?

Signature | Date | Position held in hospital | 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

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:

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.

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 UMAL seeking medical information from any doctor who at the time has attended me concerning conditions which affect my physical or mental health.
2. Please tick the appropriate box
   - ☐ 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 Tokio Marine Kiln Group Ltd.

Signature	Date

We have updated our Privacy Policy, to ensure that we continue to handle your data fairly and lawfully, in accordance with the General Data Protection Regulation that came into force on 25 May 2018.

You can review the updated Privacy Policy here.

The Privacy Policy includes information and guidance, such as:

- How we collect, use and store your personal data;
- Your rights in connection with our collection, use and storage of your personal information;
- The circumstances under which we may be obliged to share your personal data with third parties.

By signing this form, you are consenting to the terms of our Privacy Policy.

If you have any questions about our Privacy Policy, you can contact the Data Protection Officer on 020-7847 8670, or by email to DPO@umal.co.uk, or by writing to the Data Protection Officer at 5 St Helen's Place, London EC3A 6AB.

Declaration

Please remember to print this form and sign in the space below before sending the completed form – either in hard copy or as a scanned PDF to the contact details shown at the top of page 1

Name	Signature
Position	
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 your claim.