



ISSUING BRANCH
Maven Claims
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Report Form

Personal Accident & Sickness Claim

PLEASE COMPLETE ALL QUESTIONS – IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE “N/A”

Name of Policyholder:
Certificate No:

Name of Policyholder:
Certificate No:

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

EMPLOYMENT DETAILS	
What is your occupation?	
Please describe your duties:	
Name & Address of Employer:	
Please state average annual gross and net salary over previous 12 months from the date of accident and over the previous 36 months from the date of accident if self employed. Please provide evidence of salary.	
Gross:	Net:

PLEASE ENSURE YOU SIGN THE DECLARATION ON THIS CLAIM FORM

Maven Underwriters is part of AUM Europe. AUM Europe is a trading name of Aon Limited which is authorised and regulated by the Financial Services Authority in respect of insurance mediation activities only.

**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:

Height:

Weight:

Please give details of injury/illness:

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 patient still incapacitated? YES NO

If YES, when will 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 that 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.

DATA PROTECTION

In order to administer your claim, this information will be used by ACE Insurance S.A.-N.V. and its group companies and Aon 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 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 that 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 Limited are authorised by the insurer to handle claims under the Aon Protect scheme and will do so under the terms and conditions of the policy. Aon are therefore acting for the insurer. Any objections to this arrangement should be raised when first reporting the claim.

DECLARATION

I declare that all 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 your attending doctor can give 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 your comments to the report.

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

Signed: _____

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

Date: _____

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DOCUMENTS REQUIRED:

Enclosed

To Follow

Medical Certificate

PLEASE ENSURE

- θ You fully complete every question **before** your doctor completes his statement.
- θ You have enclosed all requested information/documentation.
- θ You have signed this claim form.
- θ The attending doctor fully completes this statement.

As failure to do so will result in delay in handling your claim.

Thank you for completing this form.