Hospital Claim Form

AIG Direct

This form has been designed to help you provide all the information we need to process your claim quickly. Failure to complete this form correctly may delay your claim. We recommend you have your policy to hand for reference.

If you need to attach additional sheets please use the same section headings as detailed on this form.

Please complete this form in BLOCK CAPITALS and return it to: **AIG Direct Claims Department, The AIG Building, 2-8 Altyre Road, Croydon, Surrey, CR9 2LG** or by **email to aigdirect.claims@aig.com**.

If you require assistance to complete your form or have any questions please call 020 8662 8101 and a member of our Claims Team will be able to help you, (lines are open (9:15 to 5pm, excluding public holidays)

Please complete Sections 1 to 7 and then ask your GP or consultant to complete Section 8. If any question is not applicable, please state N/A. PLEASE MAKE SURE YOU SIGN AND DATE THIS CLAIM FORM (SEE SECTIONS 6 & 7).

SECTION 1: Policy Details

Policy Number:

Claim Number:

SECTION 2: Personal Information - The claimant is the person who was admitted to hospital. If filling in the form on their behalf please complete both sections below.

Claimant's details - Person admitted to hospital

Full name and title:

Address and postcode:

Claimant's date of birth: d d | m m | y y y y

Age at time of admission:

Your details - Person completing the claim form

Full name and title:

Address and postcode:

Your relationship to the claimant:

SECTION 3: Contact Details

Daytime Telephone Number:

Mobile Number:

Email:

How would you like us to contact you with updates on the claim?

Please tick all that apply Phone ☐ email ☐ Letter ☐

SECTION 4: Additional Support

Do you require additional support in communicating with us? **Yes** ☐ **No** ☐ **Prefer not to say** ☐

If Yes, your reasons for needing additional support may be listed below - please tick all that apply

The information you provide will help us adapt your claims experience to meet your additional needs where possible.

- ☐ Difficulties with English Language Skills
- ☐ Difficulties with Numeracy Skills
- ☐ Difficulties with Digital Skills (e.g. Ability to use Technology
- ☐ Little or no Access to Help or Support
- ☐ Low Confidence in Managing this Claim
- ☐ Severe or Long-Term Health Illness
- ☐ Learning Difficulties/Disability
- ☐ Visual or Hearing Impairment
- ☐ Mental Health Condition/ Disability
- ☐ Physical Disability Leading to Mobility Issues
- ☐ Monthly Outgoings Exceeds Current Income
- ☐ Irregular Income
- ☐ Little or No Access to Savings
- ☐ **Find it Difficult to Adapt to Stressful Situations/Crisis**
- ☐ **Addiction**
- ☐ Bereavement
- ☐ Redundancy
- ☐ Retirement
- ☐ Sudden/Unexpected Drop in Income
- ☐ Caring Responsibilities
- ☐ Domestic Abuse

The personal information you provide in Section 4 will be used to help us to adapt, where possible, our handling of your claim to meet your particular circumstances. The information will be retained for as long as is considered necessary for the purpose for which it was collected and to comply with our legal and regulatory requirements.

You have the right, at any time, to request that AIG not use Personal Information that you have provided in Section 4. To give such notice please contact AIGDirect.Claims@aig.com quoting your claim number. For more information about your rights and on how we use Personal Information, please see Section 7 (How we use Personal Information) and our privacy policy available at https://www.aig.co.uk/privacy-policy.

Continue Overleaf

SECTION 5: Hospital Details

Please complete **ALL** questions. If you need to provide additional information please use separate sheet(s) of paper and attach with this form. **Your claim cannot be processed without this information.**

Please specify the reason for admission ☐ Illness ☐ Accident

If illness, what was the nature of the illness?:

Have you suffered from this type of illness before? ☐ Yes ☐ No

If yes, please state when: dd | mm | yyyy

Date of first consultation: dd | mm | yyyy

If an Accident:

Please specify exact date and time of Accident:

DATE: dd | mm | yyyy TIME:

Please specify where the accident occurred, please include Country and Town/Village where possible:

Please describe how the Accident occurred:

Hospital details, including address and name of attending hospital doctor(s):

Was a Hospital Stay Required? If yes, please confirm the dates of admission and the hospital attended and ward type:

FROM dd | mm | yyyy	TO: dd | mm | yyyy	HOSPITAL:	WARD:
FROM: dd | mm | yyyy	TO: dd | mm | yyyy	HOSPITAL:	WARD:
FROM dd | mm | yyyy	TO: dd | mm | yyyy	HOSPITAL:	WARD:
FROM: dd | mm | yyyy	TO: dd | mm | yyyy	HOSPITAL:	WARD:

Was an operation required? If yes, please confirm the nature of the operation:

Was a period o recuperation Required? If yes, please confirm the period of recuperation FROM dd | mm | yyyy TO: dd | mm | yyyy

Was there a period of home confinement on the advice of a registered medical practitioner? If yes, please confirm the period of home confinement FROM dd | mm | yyyy TO: dd | mm | yyyy

Did you attend as an outpatient? Yes ☐ No ☐

If yes, please specify the dates below:

DATE OF VISIT : dd | mm | yyyy	HOSPITAL:	WARD:
DATE OF VISIT : dd | mm | yyyy	HOSPITAL:	WARD:
DATE OF VISIT : dd | mm | yyyy	HOSPITAL:	WARD:
DATE OF VISIT : dd | mm | yyyy	HOSPITAL:	WARD:

Continue Overleaf

SECTION 6: Declaration to be completed by the Claimant - Injured Person

Access to Medical Records / Medical Reports Consent Form

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

Please give details of any Doctor who you have consulted for your injury including the name of your GP:

NAME OF YOUR GP:	NAME:
ADDRESS:	ADDRESS:
POSTCODE: TELEPHONE NO.:	POSTCODE: TELEPHONE NO.:
NAME:	NAME:
ADDRESS:	ADDRESS:
POSTCODE: TELEPHONE NO.:	POSTCODE: TELEPHONE NO.:

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.

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

SIGNED: DATE dd | mm | yyyy

FULL NAME:

IF YOU ARE SIGNING ON BEHALF OF THE CLAIMANT, PLEASE STATE THE REASON AND YOUR RELATION SHIP:

If you are signing on behalf of the claimant because you hold a Power of Attorney, please send a copy of this with the claim form.

If you are singing on behalf of the claimant and you do not hold a Power of Attorney (except in the case of a child), please send in written authorisation signed by the claimant to act on their behalf.

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SECTION 7: Declaration to be completed by the Claimant - Data Protection

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
- 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, China, Mexico Malaysia, Philippines, Bermuda and other countries 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. Further information about international transfers is set out in our Privacy Policy (see below).

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.

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

SIGNATURE: DATE d d | m m | y y

PRINT NAME:

In the event that benefit is due, please the bank details for the transfer:

ACCOUNT PAYEE (OF INSURED UNLESS A MINOR):

ACCOUNT NUMBER: SORT CODE:

BANK NAME AND POSTAL ADDRESS:

Any problems completing this claim form? Please contact us on: 020 8662 8101

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SECTION 8 – Doctors Statement – This section of the form must be completed by a Doctor to avoid delay in the assessment to the claim.

ANY FEE PAYABLE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE CLAIMANT AND NOT THE COMPANY.

Patient's name: Date of accident or illness: dd | mm | yyyy

Are you the patient's usual Medical Attendant? Yes No Is the reason for attendance **solely** to this accident/illness? Yes No

Patient's Hospital Number:

If admission is due to an accident, please confirm how the accident occurred:?

Injuries sustained (if this involves an eye or limb, please state left or right):

If an illness, please provide the full diagnosis:

Treatment:

Has surgery been performed? Yes No

If yes, please give details, including surgery date(s), if amputation, please confirm the level of amputation:

Were any fractures sustained? If yes, please confirm the site of the fracture(s) Yes No

Is there any evidence of bone disease or osteoporosis? Yes No

If yes, please confirm the date diagnosed: dd | mm | yyyy

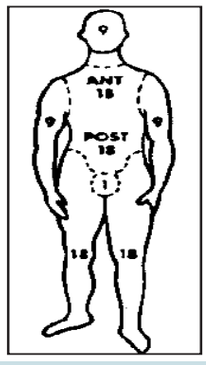
Were any dislocations sustained? Yes No

Did the dislocation require reduction under anaesthesia? Yes No

Is there any indication that alcohol was a contributory factor? Yes No

Has the patient sustained a third degree burn? Yes No

If 'Yes', please indicate the area of burns on the chart. Please give our assessment of the percentage of body surface which has been affected by third degree burns by reference to the 'Rule of Nine'



For what period was the patient confined to Hospital:

FROM dd | mm | yyyy TO: dd | mm | yyyy	HOSPITAL:	WARD:
FROM dd | mm | yyyy TO: dd | mm | yyyy	HOSPITAL:	WARD:
FROM dd | mm | yyyy TO: dd | mm | yyyy	HOSPITAL:	WARD:
FROM dd | mm | yyyy TO: dd | mm | yyyy	HOSPITAL:	WARD:

For what period was the patient confined to bed:

FROM dd | mm | yyyy TO: dd | mm | yyyy

For what period was the patient confined to the house:

FROM dd | mm | yyyy TO: dd | mm | yyyy

Continue Overleaf

SECTION 8: Doctor's Statement Continued.

Has the patient previously suffered this type of injury? Yes No If yes, please give details including date(s)

Is the patient suffering from any other medical condition or disability which is affecting their recovery? Yes No If yes, please specify:

Did any of the previous conditions contribute to their present condition? Yes No If yes, please specify:

Did this result in the patient's period of hospital being extended? Yes No If yes, please specify the number of days this was extended by:

Was a period of recuperation Required? If yes, please confirm the period of recuperation FROM dd|mm|yyyy TO: dd|mm|yyyy

Did they attend as an outpatient? Yes No

If yes, please specify the dates below:

DATE OF VISIT : dd|mm|yyyy	HOSPITAL:	WARD:
DATE OF VISIT : dd|mm|yyyy	HOSPITAL:	WARD:
DATE OF VISIT : dd|mm|yyyy	HOSPITAL:	WARD:
DATE OF VISIT : dd|mm|yyyy	HOSPITAL:	WARD:

Date Treatment first sought: dd|mm|yy Date of last visit: dd|mm|yy Total number of visits:

DECLARATION: I hereby certify that my answers to the questions in Section 8 are correct and true to the best of my knowledge and belief

SIGNATURE: DATE: dd|mm|yy

PRINT NAME: TITLE incl GMC NUMBER:

HOSPITAL/GP ADDRESS AND STAMP: