InterGlobal

Personal accident Claim form

Please complete clearly in BLOCK CAPITALS. **Are you submitting this claim as a scanned copy?** ☐ **Yes** ☐ **No**

Further information about how to complete this form can be found on the reverse.

Your claim will be processed by Aetna Global Benefits (UK) Limited on behalf of the insurer. Failure to complete all sections marked 'must be completed' on this form may result in delays.

Section A: Claimant/planholder details – must be completed

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ Male ☐ Female
Member number:	Plan number:
Correspondence address:	
Town: / Postcode: / Country:	
Email:	
Daytime phone:	Evening phone:

Section B: In the event of a claim arising from an accident resulting in death

Entitled beneficiary details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ Male ☐ Female
Correspondence address:	
Town: / Postcode: / Country:	
Email:	
Daytime phone:	Evening phone:

Provide proof you are entitled to claim for such fund under the planholder's Personal accident plan.

Section C: Claim details

Specify under which section of the Personal accident plan you are claiming.

Section D: Data Protection and Declaration – the Declaration must be signed by the claimant or by the entitled beneficiary

The words 'Aetna' and 'other Aetna entities' mean Aetna Global Benefits (UK) Limited and include any other Aetna International Inc. group company as the context requires.

Data Protection Notice

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with the UK Data Protection Act 1998, medical confidentiality guidelines, other related legislation and our own strict internal policy.

We will use any personal data we collect about you and where appropriate, your dependants, to process your claims, administer your policy, detect and prevent fraud, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

We may also, in carrying out your instructions, processing and administering claims, transfer your personal data to other Aetna entities and/or third parties acting on our behalf inside or outside the European Union where there may be less stringent data protection laws. However, wherever it is held and processed, your personal data will be protected by a strict code of security which we and any third parties working on our behalf are subject to and will only be used in accordance with our instructions.

Your information may also be used for the detection and prevention of fraud and for audit purposes. Aetna works with other insurance providers, regulatory bodies and law enforcement organisations to prevent and detect fraud.

We will not disclose any such information outside of the Company, including any third parties working on our behalf, except for fraud prevention purposes, and/or if required/obliged by law or governmental or judicial bodies or agencies or to our regulators under proper authority.

Your medical information will only be disclosed to those involved with your treatment or care, including your general practitioner/primary health physician, or to their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents.

We will communicate directly with you about your claim. Claims information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information; or to another person that you have authorised us to provide such information.

If you want us to disclose your medical information to another individual or next of kin, please complete the section below.

I would like information about this claim to be provided to:

Name:	Relationship:

Declaration

I declare that all the details given on this Claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I may be committing a criminal offence and that this may invalidate the plan and make me liable to prosecution. For this claim I authorise any medical practitioner, specialist or other relevant establishment who has attended me/the claimant in the past, or is attending me/the claimant at present, to give any details that may be asked for by the insurer or any authorised administrator.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, (on behalf of myself and any family members specified in this form) for Aetna Insurance Company Limited (the insurer) to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members.

(Our full terms and conditions and details of our privacy policy can be found at www.interglobalpmi.com)

I authorise and request any hospital, specialist, physician or other health provider to furnish the insurer or its duly authorised agent acting on its behalf with such information as the insurer or such agent may seek from them in connection with any treatment or other services provided to me or my dependant/s for the purpose of the insurer considering this claim.

I have been advised of my rights under the Access to Medical Reports Act 1988.

I do (not)* wish to see a copy of any medical report before it is sent to the insurer. (*Delete the word NOT if you wish to see a copy of the medical report before it is sent to the insurer).

Claimant's/entitled beneficiary's signature:	Date (dd/mm/yyyy):

Section E: Accident details

Date of accident (dd/mm/yyyy):

Time of accident:

Place of accident:

Full description of accident:

Use a separate document if you need more space to describe the accident.

What injuries did you sustain?

Have you ever had any previous medical conditions relating to this part of your body? ☐ Yes ☐ No

If 'Yes', please give details:

Is this injury a result of a road traffic accident? ☐ Yes ☐ No

Was the road traffic accident reported to the police? ☐ Yes ☐ No

If 'Yes', send us a copy of the police report.

Is there a pending prosecution against you? ☐ Yes ☐ No

Is this an injury that happened in your workplace? ☐ Yes ☐ No

If 'Yes', provide your employee contact details on a separate document.

Give the name(s) and address(es) of every doctor consulted for the present injury, including your medical practitioner/specialist.

Name of medical practitioner/specialist: Qualifications:

Address:

Telephone number:

Email:

Section F: Treating doctor's statement – must be completed by the treating doctor to avoid delays in assessing the claim

Name of claimant:

Date of accident (dd/mm/yyyy):

Are you the claimant's usual medical practitioner? ☐ Yes ☐ No

Is the claimant's disability due solely to this accident? ☐ Yes ☐ No

Accident details, including the cause:

Is there any indication that alcohol or other intoxicating substance was a contributory factor to the accident? ☐ Yes ☐ No

Has the accident resulted in the claimant's death? ☐ Yes ☐ No

If 'Yes', the questions below do not need to be responded to. Please sign the declaration at the bottom of this section.

If the injury sustained involves an eye or limb please state left or right: ☐ Left ☐ Right

Diagnosis:

Treatment:

Was a surgical procedure performed? ☐ Yes ☐ No

If 'Yes', give details, including date(s):

Section F: Treating doctor's statement (continued)

Were any fractures sustained? ☐ Yes ☐ No

If 'Yes', confirm site of fractures:

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

If 'Yes', confirm date diagnosed (dd/mm/yyyy):

Has the claimant suffered a third degree burn? ☐ Yes ☐ No

If 'Yes', provide details about the area of burns. Give your assessment of the percentage of body surface which has been affected by third degree burns by reference to the 'Rule of Nines'.

At the time of the accident, was the claimant suffering from any other sickness or disease? ☐ Yes ☐ No

If 'Yes', give details with medication prescribed and advise whether this will delay recovery of present disability:

Has the claimant previously suffered this type of injury? ☐ Yes ☐ No

If 'Yes', give details, including date(s):

Is the claimant suffering from any other medical condition or disability which is affecting their recovery? ☐ Yes ☐ No

If 'Yes', please specify:

In your opinion, do you think the claimant will be left with a permanent disability solely as a result of the accident? ☐ Yes ☐ No

If 'Yes', give full details (including whether it is partial or total disability, treatment and medication).

Declaration

I declare that to the best of my knowledge and belief the information I have given in this section of the Claim form is full, true and complete.

Medical practitioner's/specialist's signature:	Practice stamp:
Date (dd/mm/yyyy):	

Section G: Payment details – must be completed

You must tell us how you wish to be reimbursed by ticking either 1, 'Bank transfer' or 2, 'Foreign draft', and completing the required information.

We will only issue payment to:

- the planholder; or
- the entitled beneficiary in the event of the planholder's death.

Failure to complete all information for the chosen payment method may result in you, the named person or entity:

- experiencing delays in receiving the claim settlement; and
- incurring additional bank charges.

☐ 1. Bank transfer – this is the quickest and safest method of payment

Name of account holder:

If the claimant's name (as given in section A) is different to the account holder name, please provide the following details:

Address of account holder:

Email address of account holder:

Telephone number of account holder:

Bank account details:

Bank name:

Bank address (including town and city):

BIC/SWIFT code:

Currency of bank account:

Account number:

To help us direct your payments efficiently, supply the following as relevant:

IBAN number (mandatory for all payments to bank accounts in countries that have adopted IBAN):

Sort code (mandatory for UK located banks):

Routing code/Branch code (as available):

ABA number (mandatory for transfers to US located banks):

☐ 2. Foreign draft

Name to appear on the draft:

Currency of the draft:

Important information

Please remember these important points when completing your Claim form:

- Assessment of your claim may be delayed if you and the medical practitioner/treating doctor do not complete all the necessary sections of this form.
- Send your claim to us as soon as possible. We recommend that you do so within a maximum period of six (6) months of the accident date.

Make sure that you complete sections A-E and G, and that all the relevant doctors complete section F.

Sections D and F

- If the declarations have not been read and signed, we will not be able to process your claim.

Section G – Payment details

You need to tell us how you wish to be paid.

i. Ensure that you are able to receive payment in the method and currency you have requested.

ii. We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.

iii. We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details.

iv. If you do not give us the sort code/routing code, BIC/SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.

v. Payment by foreign draft in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft. We strongly recommend that, wherever possible, you choose to be paid by bank transfer as this is the quickest and safest method of payment.

vi. We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the currency of your plan. For the current list of applicable currencies and countries please refer to our website.

vii. We cannot issue foreign drafts to banks based in Qatar.

viii. Please note that we are unable to make claim payment reimbursements via bank transfers to Japan Post Banks as they do not accept international remittances.

ix. Japanese banks will often charge for processing a foreign draft. Most Japanese banks will not process foreign drafts in any currency other than Japanese Yen.

x. Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of the payment and is outside our control.

Checklist

There are two ways to send your claim to us:

1. By post – have you included:

- a fully completed Claim form with signed and dated declarations? ☐
- an original Police report if relevant? ☐
- where relevant, proof you are entitled to claim for such fund under the planholder's Personal accident plan if you are the entitled beneficiary? ☐

2. By email – have you read the scanned claims acceptance criteria? ☐

You will find the criteria for accepting scanned claims in your Claims procedures or in the Members section at www.interglobalpmi.com

Please call us on Toll Free: 00 53 164 2084 or email IGSGClaims@aetna.com if you require any further assistance.

Send your claim to: Claims Team, Aetna Global Benefits (UK) Limited (Singapore Branch), 80 Robinson Road, #23-02/03, Singapore 068898.