


# 50+ & 60+ PERSONAL ACCIDENT PLAN CLAIM FORM

**Please return the form to:**
**By Post:**
**Claims Department**
**Union Income Benefit**
**154 - 160 Fleet Street**
**Blackfriars**
**London**
**EC4A 2DQ**

**By Email:**
**claims@uibuk.com**

**If you have any queries regarding your cover or require guidance in completing this form then please contact our claims helpline on Telephone: 0800 014 7024 or by Email: claims@uibuk.com**
Lines open Mon to Fri 9 a.m. to 6 p.m. Telephone calls may be recorded for monitoring and quality purposes.

Before going ahead with a claim please read your policy and schedule to make sure that you understand your cover and any exclusions.

Claims under your policy will be handled by Union Income Benefit.

## Completion of Claim Form

In order for us to deal with your claim promptly please complete **Section A** of this form yourself. Please ask the General Practitioner, Hospital Consultant or Doctor attending to complete **Section B** of this form.

Please complete all relevant parts of the form, write in BLOCK CAPITALS and tick any boxes as appropriate. **Please refer to your Policy Schedule for details of cover.**

Please note you will be responsible for any expenses which may be incurred in the completion of this claim form, for more information on this please refer to section 8 of the Policy Wording.

Please ensure that you sign and date the Declaration and Consent at the end of the claim form. Please ensure that you read the Data Protection Notice on p11 and the information relating to the rights under the Access to Medical reports on p8 of this document.

## Important Notes

The questions on this form and any other questions which we specifically ask, relate to facts considered to be material to the handling of your claim. Please answer them fully and honestly and supply any additional relevant information. Failure to do so may not only invalidate this claim but also the insurance provided by the policy as a whole.

## Checklist

Please return the completed claims form together with any enclosures to Claims Department, Union Income Benefit, 154 - 160 Fleet Street, Blackfriars, London, EC4A 2DQ, or email to claims@uibuk.com and please ensure:

- [ ] You fully complete every question **before** your Qualified Medical Practitioner completes **Section B**
- [ ] You have enclosed all requested original documents (we recommend you retain copies)
- [ ] You have signed this claim form
- [ ] Your attending doctor fully completes the statement
- [ ] All documents that are scanned and sent by email are clear and copied in full

Failure to complete the form in full may result in delay in handling your claim.

## Section A:1 - Personal details

PLEASE WRITE IN BLACK INK AND USE BLOCK CAPITAL LETTERS. ALL SECTIONS MUST BE COMPLETED OR MARKED 'NOT APPLICABLE'. PLEASE REFER TO YOUR POLICY SCHEDULE FOR DETAILS OF COVER. COMPLETE THE CHECKLIST AND ENSURE THAT YOU SIGN THE DECLARATION AT THE END OF THIS FORM.

## Policyholder's details

| | | |
|---|---|---|
| Policyholder | Policy number | |
| Insured Person forename | Insured Person surname | Insured Person date of birth |
| Policyholder Address | | |
| Postcode | | |
| Cover type<br>Single ☐ Joint ☐ | Email address | |
| Landline Telephone | Mobile Telephone | |

## Injured person's details

**To be completed in respect of the person injured**
**(a separate claim form should be completed for each person wishing to claim)**

| | |
|---|---|
| Full name (if Policyholder state 'as above') | |
| Address (if different from above) | |
| Postcode | |
| Relationship to Policyholder | Email address |
| Landline Telephone | Mobile Telephone |

**If not the Policyholder, claimant's details**

| | |
|---|---|
| Full name | |
| Address | |
| Postcode | |
| Relationship to Policyholder | Email address |
| Landline Telephone | Mobile Telephone |

**For what is the claim being made:** Accidental death ☐ Injury ☐

**Only applicable for an accidental death claim: Grant of representation/probate is required.**

**Please confirm you have enclosed it:** Yes ☐ No ☐

## Section A:2 - Details of the accident

| Location of accident | Date of accident | Time of accident |
|---|---|---|
| | | |

Please give full details of the nature and severity of the injuries sustained and how the accident occurred indicating what the claimant was doing at the time. Please give as much information as possible about what caused the accident to happen.

| | |
|---|---|
| Was the claimant a driver or passenger?<br>Driver ☐ Passenger ☐<br>Did the Police attend at the time of the accident?<br>Yes ☐ No ☐<br>If "no" was the accident reported to the Police?<br>Yes ☐ No ☐ | Name of the Police Officer and Address of Station involved |
| Accident reference number | |
| If a motor accident, is there any prosecution pending for drink-driving?<br>Yes ☐ No ☐ | If the accident took place at work, was it noted in the accident book?<br>Yes ☐ No ☐ |
| A:1.2: Name, address and telephone number of the Employer | |

| | | |
|---|---|---|
| If the accident took place overseas: Date claimant left the United Kingdom | Date returned | Purpose of visit |
| Passport number | | Airline used and flight number |
| If Accident was in a European Economic Area country did you obtain the European Health Insurance (EHIC) card?<br>Yes ☐ No ☐ **If yes, please attach** | | |
| Please give names, address and telephone numbers of witnesses, if any. | | |

## Section A:3 - Medical care

**Please note that Section B of this form must be completed by the Qualified Medical Practitioner in attendance.**

| | | |
|---|---|---|
| Name, address and telephone number of the claimant's Qualified Medical Practitioner | | |
| Name, address and telephone number of attending Qualified Medical Practitioner if different from above | | |
| Date on which Doctor was first consulted | Date on which the claimant last worked | Did the claimant attend a Casualty Department<br>Yes ☐ No ☐ |

| | |
|---|---|
| If "yes" please give name, full postal address and telephone number of hospital attended. | Date attended |

## Section A:4 - Other insurances

**Please give details of any other insurance claims arising from this accident including Motor Insurance.**

| Name and full address of insurers |
|---|
| Policy numbers |

## Section B:1 - Medical certificate
**(to be completed in all cases by the Qualified Medical Practitioner in attendance)**

**NB any fee is payable by the patient.**

**This is to certify that the patient named below**
suffered the injuries indicated below as the direct result of the Accident stated in **Section A:2** of this Claim Form

| Full name of patient | | | |
|---|---|---|---|
| Patient's date of birth | Accident date | Hospital admission date | Discharge date |

## Table of injuries

**1. Fractures**

Please note which bone or bones were broken in the incident, and also confirm the formal fracture diagnosis for each

Does your patient suffer from any bone weakening conditions such as Osteoporosis?

Yes ☐ No ☐

If your answer is "Yes" please confirm the name of the condition suffered?

**2. Burns**

☐ Third degree burns to 15% or more of body surface or 50% of either hand

☐ Third degree burns to at least 4% but to less than 15% of body surface (except hands)

☐ Second degree burns of 9% or more of body surface

**3. Dislocations** Please provide details, and specify if more than one dislocation

| **4. Accidental Death** Date of death | Death certificate enclosed<br>Yes ☐ No ☐<br>**(please send a certified copy not the original)** |
|---|---|
| If no certified copy of death certificate enclosed, please explain why | |
| If the injury suffered is not listed please state precisely the nature of the injury | |

## Other Medical Information Required

| What date did the patient first seek medical consultation from his Qualified Medical Practitioner for this, or a connected condition? | When was the patient first referred to you in connection with the above condition? |
|---|---|
| Name and Address of the attended Hospital | |
| Were the injuries treated solely as a result of the accident described in **Section A:2** of this claim form?<br>Yes ☐ No ☐ **If "no" please give full details** | |
| Hospital Patient Number | Telephone number |
| Official Stamp | |
| Signature of Qualified Medical Practitioner<br>Date | |
| Name and Qualifications | |

## Declaration and Consent

I declare to the best of my knowledge and belief all the information given in this form is complete, true and correct.

If the information given on my behalf in **Section B** is inadequate for the purpose of my claim, I consent to Union Income Benefit obtaining a medical report from my Qualified Medical Practitioner relating to the history and nature of the condition and/or its treatment.

I am aware of my rights as detailed on page 8 under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 and agree that a copy of this consent shall have the validity of the original.

☐ I do wish to see the medical report before it is sent to Union Income Benefit

☐ I do not wish to see a copy of the medical report before it is sent to Union Income Benefit

## Your rights under the Access to Medical Reports Act (1988) and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991

Before giving your consent for us to obtain a medical report, please ensure you read these notes carefully as they set out your rights under the Access to Medical Reports Act 1988 and the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991.

- You do not have to give your consent, but if that is the case we may be unable to proceed with the claim.
- If you give your consent, we will inform the Doctor of this at the time we request the medical report.
- You will then have the right to advise the Doctor, in writing, that you wish to see the report before it is sent to us. If you do this, the Doctor cannot send us the report until either:-

  a) you have seen the report and consented in writing to it being sent to us, or

  b) 21 days have passed and you have not asked the Doctor to see the report.
- It is your responsibility to make arrangements with your Doctor to see the report which has been prepared. The quicker you act the quicker we can proceed with your claim.
- Even if you did not originally wish to see the report, you can change your mind. In these circumstances, you must inform both us and the Doctor. You will then have 21 days to contact the Doctor to arrange to see the report.
- Whether or not you ask to see the report which is sent to us, you also have the right to ask your Doctor to let you see a copy, provided that you make your request within the six months after the report was sent to us.
- If you see any report, in accordance with your rights, the Doctor will need your consent before he/she can send it to us.
- If you disagree with the content of the report, you can write to the Doctor asking him/her to amend any part of the report which you consider to be incorrect or misleading.
- If you and your Doctor cannot agree on the facts set out in the report, you have the right to ask him/her to attach a statement of your views on any part of the report which you disagree with and which the Doctor is not prepared to alter.
- The Doctor is not obliged to let you see any part of the report if:-

  a) in his/her opinion, it would be likely to cause serious harm to your physical or mental health or that of others, or

  b) it would indicate the Doctors intentions in respect of you, or

  c) disclosure would be likely to reveal information about, or the identity of, another person who has supplied information about you, unless that person has consented to, or the information relates to, or has been supplied by, a health professional involved in caring for you.

  In such cases, the Doctor must notify you accordingly and you will be able to see only the remainder of the report. If the whole report is affected, he/she must not send it to us unless you give your consent.
- We will pay for the original report but if you ask for a copy, the Doctor can charge a reasonable fee to cover the cost of supplying it.

To be signed by the Policyholder or in the event of an Accidental Death claim for the Policyholder this should be signed by the Policyholder's legal representative.

| | |
|---|---|
| | Date |

To be signed by the injured person if other than the Policyholder.

| | |
|---|---|
| | Date |

**Please return this form by email: claims@uibuk.com**
**Or by post: Claims Department, Union Income Benefit,**
**154 - 160 Fleet Street, Blackfriars, London, EC4A 2DQ**

## Section C - Data Protection Act 2018 Consent Form

You may wish for a family member or your legal representative to be given access to your personal and medical information in order to help you with your claim.

In order for us to be able to discuss your claim with anyone other than yourself or our appointed agents we need your specific written permission. Please note that this consent would not allow anyone other than yourself to receive any benefit payments.

You may activate or cancel your permission at any stage throughout your claim. Please contact us should you wish to make any changes.

| | |
|---|---|
| Certificate number or Policy number | |
| Do you wish for your personal information to be given out to a family member or legal representative?<br>Yes ☐ No ☐ | |
| If **YES** then please complete the following section: | |
| The name of your appointed family member or legal representative | |
| Their relationship to you | Their date of birth |
| Their contact address | |
| | Postcode |

**How we use your personal information:** We will use the personal information you provide, including information about your health where necessary, to assess, administer and manage your claim. We may also share relevant information with third parties involved in the assessment and administration of your claim. Further information about how we use your personal information, our lawful basis for processing, who we share information with, how long we retain it and your rights is available in our Privacy Notice at https://unioninsurance.co.uk/privacy-policy/

## Claim Form Declaration

**I hereby declare that the statements in this claim form are true in every respect to the best of my knowledge and belief and that I have disclosed all information likely to influence the assessment of my claim. I consent to the seeking of information from my present employer and any doctor who has treated me or any person/ organisation that is deemed necessary to check the answers I have provided, and I authorise the giving of such information. A copy of this authorisation shall be considered as effective and valid as the original. I understand that information regarding my claim may be shared with other insurers, loss adjustors, the Police and the Benefits Agency for fraud detection and prevention purposes.**

| | |
|---|---|
| Signature | Date |

# Data Protection Notice

The Personal Information you provide.

Stonebridge International Insurance Ltd the insurer (we/us) and Union Income Benefit Holdings Ltd, the administrator, are the separate data controllers (as defined in the Data Protection Act 2018 and any successor regulation (DPA)) and fully accept the responsibility of protecting the privacy of customers and the confidentiality and security of personal information provided to either party.

In this notice, Personal Information is personal data (as defined in the DPA) and means any information that identifies an individual and includes any special category personal information (as defined in the DPA e.g. information about health or medical condition(s)).

Where this notice refers to you or your Personal Information, this will include any information that identifies another person whose information you have provided to us or the administrator. We and the administrator will assume that they have appointed you to act or them. You agree to receive on their behalf any data protection notices from us or the administrator.

Your Personal Information will be used for the purpose of providing insurance services: to decide if we can offer insurance to you; to administer your policy and to handle claims. The Personal Information we collect will include name, address, date of birth and financial information. If a claim is made, we will collect additional information about the claim. Where this includes special category data e.g. information relating to health, where appropriate we will ask you for consent to collect this information.

Your Personal Information will be used by us and the administrator for legitimate interests we or the administrator have as a business including customer profiling to better understand customers, improve products and to suggest other products that may be relevant to customers including marketing and for management and audit of business operations. We or the administrator will only communicate with you in line with any marketing preferences that you have given us or the administrator and this may continue after your policy has ended.

Your marketing preferences can be updated at any time by contacting the administrator: By email: customercare@uibuk.com

By phone: 0343 178 1255

By post: Customer Services, Union Income Benefit, 154 - 160 Fleet Street, Blackfriars, London, EC4A 2DQ.

We or the administrator may share your Personal Information with the Embignell group, reinsurers, business partners and agents to help administer the products and services and to keep regulatory obligations.

We or the administrator may also pass your Personal Information to other insurers and regulatory and law enforcement bodies for the prevention of fraud, financial crime or where the law requires us or the administrator to do so.

We or the administrator may transfer your Personal Information to countries outside the United Kingdom and the European Economic Area (EEA) which may not have the same level of data protection as in the United Kingdom, but if this is necessary it will be ensured that appropriate safeguards are in place to protect your Personal Information.

We may carry out automated decision making based on your Personal Information. This will include your age and the level of cover and is used to calculate the price of cover that we provide.

We and the administrator may monitor and/or record your communication with us or the administrator, either ourselves or using reputable organisations selected by us, to ensure consistent servicing levels and operations.

We or the administrator will keep information about you only for so long as it is appropriate. We and the administrator need your personal information to administer your policy or handle any claims whilst your policy is in force.

We may need to keep information after your policy has ended to ensure we and the administrator have an accurate record of our relationship to you and communications that we or the administrator had or where we are required to keep the information for legal, regulatory or tax purposes.

You have the right to ask us to delete your data or cease processing it at any time, however we may not be able to do this if we require your data in respect of our contract with you. The administrator has a dedicated Data Protection Officer who you can contact for any queries or to exercise any of your rights under data protection regulations including: data subject access requests, correcting your information, making a complaint regarding the use of your data. If you believe we or the administrator are holding inaccurate information about you or wish to request a copy of your information, you should contact the administrator.

Contact Details:
Data Protection Officer
By email: dataprotection@embignell.com
By post: Data Protection Team, Union Income Benefit, 154 - 160 Fleet Street, Blackfriars, London, EC4A 2DQ

The information that you have requested will be provided in a suitable format to meet your requirements.

If the complaint cannot be resolved to your satisfaction, you can contact the Information Commissioner's Office who are the Supervisory Authority in the UK protecting the rights of individuals under current Data Protection regulations.

Website: www.ico.org.uk
By post: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF
By telephone: 0303 123 1113

More detail is also available in the administrator's Privacy Policy which can be viewed online at https://unioninsurance.co.uk/privacy-policy/

**THIS PAGE TO BE RETAINED BY YOU**



9759 SIIL (10 -2026)