Individual Income Protection Insurance Claim Form

Claimant's Name:_____

Policy Number(s):_____

IMPORTANT INFORMATION: Please read before completing this form.

We need the information in this form so that we can get a clear picture of your situation. The information that we require includes medical and financial details and may include some sensitive personal data. The information you provide will be used by Aviva in connection with this insurance, and in particular your claim under the policy. We will use it for claims handling, rehabilitation and preventing fraud.

We appreciate that we do ask for a lot of information. We rely upon this information to make a fair and valid assessment of your claim. We firmly believe it is in everyone's interest to get all the relevant information as soon as possible so we can assess your claim fairly and as early as we can.

If you fail to disclose relevant information or if you give false information, then the protection provided by this policy could be lost or cancelled and any claim could be rejected or reduced. It is, therefore, essential that you provide accurate and comprehensive answers and avoid the use of strokes or dashes.

You must answer all the questions as accurately and fully as possible. If you do not, it might delay the payment of your claim, and it might even result in the rejection of the claim and the cancellation of your policy.

You might also make the policy, or the claim, invalid if you do not inform us immediately of any change in your work, medical or financial situation as described in this form. Therefore, you must keep us informed of all such changes throughout **the course of your claim.**

The issue of this claim form is not an admittance of liability.

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FAILURE TO GIVE ACCURATE AND COMPLETE INFORMATION MAY RESULT IN NON PAYMENT OF A CLAIM

Section A: Personal Details

1. Title — Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other Please Specify
2. Surname
3. Forename(s)
4. Current residential address
   Town:
   County: Postcode:
5. Home telephone number (including STD code)
6. Daytime telephone number (if different to above)
7. Mobile telephone number
8. E-mail address
9. Date of Birth (dd/mm/yyyy)
10. Nationality (e.g. British)
11. National Insurance Number
12. Are you right or left handed? Right ☐ Left ☐
13. What is your height? ft ins or m
14. What is your weight? st lbs or kg
15. Marital status
16. Do you have any dependants? Yes ☐ No ☐

    If Yes, please state how many and their ages — Number of dependants ☐ Ages of dependants

Section B: Your Incapacity (Your inability to work as a result of illness or injury)

1. a) What is the cause of your current incapacity?

   b) Was this due to an accident? Yes ☐ No ☐

   If Yes, please give date, time, place and a full description of the accident.
   Date: Time: Place:

   If this accident required police involvement please provide an Incident Number together with details of the Police Officer and Station dealing with the accident.
   Incident Number:
   Police Officer:
   Station details:

   If this was an accident at work has this been recorded in your Employer's Accident Record book? Yes ☐ No ☐

   Is there any litigation pending or being considered that arises from this incapacity? Yes ☐ No ☐

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

If Yes, please provide full details of your legal representative:

Contact Name

Address

Town:

County: Postcode:

Telephone number (including STD code)

2. When did you first seek medical advice about your illness or injury?

3. From what date have you been continuously off work?

4. Did this follow a period of work in a reduced capacity? Yes ☐ No ☐

If Yes, please provide full details:

5. Who did you first seek advice from (e.g. doctor, hospital, clinic)?

Full name

Speciality

Department

Address

Town:

County: Postcode:

Telephone number (including STD code)

6. When did you last consult this person?

7. Have you been discharged from their care? Yes ☐ No ☐ If No, when is your next planned appointment?

Please provide below the full name and address of all the medical practitioners/therapists you have consulted regarding this incapacity. These details are needed to enable us to write to the relevant medical practitioners/advisers for evidence of your condition. If you provide incomplete details, this can delay the medical assessment of your claim.

8. Who is your **current** General Practitioner?

Full name

Full postal address

Town:

County: Postcode:

Telephone number (including STD code)

Date (approx) you registered at this practice

9. If you have been registered with this practice for less than 6 months, please provide details of your former General Practitioner.

Full name

Full postal address

Town:

County: Postcode:

Telephone number (including STD code)

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

Date (approx) of leaving this practice

Last consultation date | Next consultation date

10. Have you consulted your **current** General Practitioner with regard to this incapacity? Yes ☐ No ☐

11. Who else have you seen in connection with your current incapacity?
(Please provide details of any other doctor, consultant, specialists, private consultations, alternative therapists and treatment)

Full name		
Speciality		
Department name		
Full postal address	Town: County: Postcode:	Town: County: Postcode:
Telephone number (including STD code)		
	First Date / Last Date	First Date / Last Date
Consultations		
Your Hospital Number(s)		

12. a) What investigations and subsequent treatment have you received for this incapacity? Please provide full details.

b) Are you aware of any plans for any further investigations or treatment regarding your incapacity? Yes ☐ No ☐

If Yes, please provide full details.

13. Do you use physical aids as a result of your current incapacity? Yes ☐ No ☐
If Yes, please provide details of the physical aids you use and the frequency of use.

Aids used:	Frequency:

14. a) What medication are you currently taking, whether prescribed or not? Please provide full details including dosage and frequency of use.

Medication:	Dosage:	Frequency:	Is this prescribed?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

b) Do you experience any side effects from taking this medication? Yes ☐ No ☐

If Yes, please provide full details.

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

FAILURE TO GIVE ACCURATE AND COMPLETE INFORMATION MAY RESULT IN NON PAYMENT OF A CLAIM

15. What relief from symptoms are your current treatment/physical aids giving you?

16. a) Does the severity of your condition vary? Yes ☐ No ☐
If Yes, how do you manage this and what do you do to relieve the symptoms?

b) How often are you limited or restricted by your condition and how long does this usually last?
How often:
Duration:

c) What restrictions and limitations currently prevent you from returning to your normal occupational duties?

17. a) What parts of your job could you still do?

b) What other aspects of your job could you do if you received support (e.g. with specialist equipment, adaptations at work, transport to work)?

18. Have you made any attempt to return to your own or any other job, whether paid or unpaid, since the date you have been continuously off work? Yes ☐ No ☐
If Yes, please give full details

If No, or if a return to work was unsuccessful, when do you think you will be fit enough to return to work?

19. Have you suffered before from this incapacity or similar? Yes ☐ No ☐
If Yes, please give full details including dates and who you consulted.
Dates:
Who you consulted and where:

20. Prior to the date of your current incapacity, have you had any time off work in the last 2 years due to an illness or injury? (Please ignore any time off work for minor ailments such as colds/flu if together they total 10 days or less each year). Yes ☐ No ☐
If Yes, please tell us what prevented you from working and the length of time you had off work.
Length of time:

21. Do you currently or have you ever smoked (cigarettes, cigars or pipe), or used nicotine replacement products (nicotine gum, patches etc)? Yes ☐ No ☐
If Yes, please give full details including dates, amount smoked, whether you used nicotine replacement products and details of any dates when you have not smoked.

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

Section C: Your Occupation (It is your ability to undertake the duties of the generic occupation rather than specific requirements of an employer)

1. What was your occupation(s) immediately prior to incapacity?

2. a) Is this a management/ supervisory position? Yes ☐ No ☐ If Yes, how many staff are under your control?

   b) How many of those directly report to you?

   c) Who do you report to?

   d) What is their role or position within the company?

3. a) What are your main duties and responsibilities?

   b) Do you have a written job description? Yes ☐ No ☐
   If Yes, please provide a copy.

   c) Has your occupation changed or altered since the job description was issued? Yes ☐ No ☐

   If Yes, please provide full details.

4. How many hours are you contracted to work each week? hours per week

5. How many hours do you normally work each week? hours per week

6. What is your normal working pattern each week? (e.g. shift work, weekend work or being 'on call')

7. How many days each week do you work? days

Working environment:

Please describe and give details of the following:

1. The area in which you normally work (office, factory, warehouse, outdoors, home-based etc).

2. Any machinery, computer technology or tools you are required to use to perform the main and essential duties of your occupation.

3. Any environmental conditions that affect your ability to work in that area (e.g. dust, fumes, chemicals, noise, extreme temperature, working at heights, offshore work, diving or underground work etc).

Work skills:

1. What special skills are required to perform your normal occupation(s)?

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

2. What level of experience is necessary?

3. Are any formal qualifications needed or recommended? Yes ☐ No ☐

If Yes, please provide full details.

4. Do you hold the formal qualifications? Yes ☐ No ☐

Work requirements:

1. Please specify if any of the following form part of the main and essential duties of your normal occupation and state the average length of time you are normally required to do them each week:

			Hours per week				Hours per week
in meetings at your usual business address	Yes ☐	No ☐		attend off site meetings	Yes ☐	No ☐	
deal with or have regular meetings with customers/clients	Yes ☐	No ☐		working at a computer	Yes ☐	No ☐	
on the telephone	Yes ☐	No ☐		general administration	Yes ☐	No ☐	
training/coaching others	Yes ☐	No ☐					

Physical requirements:

1. Does your occupation require you to carry or lift? Yes ☐ No ☐

If Yes, how long do you spend carrying or lifting items weighing.

up to 10lbs (5kg)	mins per day	example of activity
up to 50lbs (25kg)	mins per day	example of activity
over 50lbs (25kg)	mins per day	example of activity

2. Are there any aspects of your occupational duties that require you to climb, stretch, push/pull, sit etc. on a regular basis? If Yes, please provide the following details. **If no, please go to question 3** Yes ☐ No ☐

Walking	mins per day	
Standing	mins per day	
Sitting (other than driving)	mins per day	
Reaching above shoulder level	mins per day	example of activity
Climbing ladders or similar	mins per day	example of activity
Crawling/kneeling	mins per day	example of activity
Pushing/pulling	mins per day	example of activity

Please give details of any prolonged activity

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

3. Do you have access to any physical aids, such as hoists or trolleys to help with lifting and carrying weights?
If Yes, please provide details:

Yes ☐ No ☐

Example of activity:	Hours per week:

4. Do you need to use your hands for repetitive actions such as:

	Right		Left	
Simple grasping	Yes ☐	No ☐	Yes ☐	No ☐
Fine manipulation	Yes ☐	No ☐	Yes ☐	No ☐

If Yes, please give details.

5. If you are required to maintain one position for prolonged periods, please give details:

6. Is it essential for you to travel during the course of your normal duties? **(Please do not include travel to and from your normal place of work)**.

Yes ☐ No ☐

If Yes, what mode of transport do you use? (If a vehicle, please indicate if this is a company vehicle or your own vehicle).
If No, please go to question 7

How many miles per week do you drive on business? **(Please do not include travel to and from your normal place of work)**.

miles per week

7. Are you required to travel abroad on business on a regular basis?
If Yes, please state which countries and how often you travel to these locations.

Yes ☐ No ☐

County	Frequency per annum

8. Please describe any other physical aspect of your work not already covered in this section.

Return to work:

1. Is your job still available to you?

Yes ☐ No ☐

If No, has an alternative position been offered to you?

Yes ☐ No ☐

If an alternative occupation has been offered to you, please provide details.

2. What contact have you had with your employer since your absence from work began? Please provide full details.

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

3. Please provide details of any discussions you have had with your employer concerning rehabilitation, reintegration programmes or perhaps a structured return to work in either your own or an alternative role.

4. What adaptations do you think could be made to enable you to return to work in your normal occupation or an alternative role?

5. What has been done already, or what future plans does your employer have, to achieve this goal?

6. Do you know if your employer has access to the services of an occupational health specialist to help employees return to work?

Yes ☐ No ☐ Do not know ☐

7. Has your employer referred you to the services of an occupational health specialist? If Yes, please provide your understanding as to the reason for the referral to the occupational health therapist (for example to discuss a potential structured return to work programme or to assess your workstation).

Yes ☐ No ☐

Date:

Name of occupational therapist

Full postal address

Town:

County: Postcode:

Telephone number (including STD code)

First consultation date | Last consultation date | Next consultation date

Section D: Other Employment

1. Have you changed your occupational role with your current employer within the last three years?

Yes ☐ No ☐ **If No, please proceed to Section E.**

If Yes, please give details of your former role, the date of the change and the reason for the change.

Date: Reason:

2. Have you had any other employment (employed or self-employed) in the last three years?

Yes ☐ No ☐

If Yes, please provide your history of employment in reverse chronological order, i.e. giving details of your most recent employment first:

Name of Employer 1. 2.

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

Or was this on a self-employed basis?	Yes ☐ No ☐	Yes ☐ No ☐
Business address	Town: County: Postcode:	Town: County: Postcode:
Telephone number (including STD code)		
Nature of Business		
Employee number		
Date of joining		
Date of leaving		
Was this your own company?	Yes ☐ No ☐	Yes ☐ No ☐
Reason for leaving		
Please provide a brief description of your duties.		

3. Please provide a brief summary of any previous training or occupation experience you may have:

Section E: Your Earned Income

The following section is divided into 3 parts. The information is required to enable us to complete the financial assessment of your claim, (for more information please refer to the limitation of benefit section of your policy conditions). **It may be that your policy does not allow us to take all sources of income into account in the financial assessment of your claim**. However, to avoid any unnecessary delay, please provide all the information below.

If you are **employed** please **complete part 1**.

If you are **self-employed** please **complete part 2**.

If you are both **employed and self-employed** please **complete both part 1 and/or part 2**.

If you are a **contract worker** please **complete part 3 together with part 1 and/or part 2, as applicable** to your circumstances.

Part 1: I am employed (We regard Directors of own Limited Companies as employed)

1. Who was your employer(s) at the date of incapacity?

Name of employer	
Nature of employer's business	
Number of employees	
Name of Line manager or Human Resources manager	

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

FAILURE TO GIVE ACCURATE AND COMPLETE INFORMATION MAY RESULT IN NON PAYMENT OF A CLAIM

Full postal address

Town:

County: Postcode:

Telephone number Including STD code)

Your employee reference

Date of Joining

2. What is your tax reference?

3. Please provide the address of the HM Revenue & Customs Office where your tax returns are submitted.

Full postal address

Town:

County: Postcode:

4. What was your gross taxable earned income for PAYE purposes during the 52 weeks before incapacity?

£

- **Please ensure you enclose a copy of your latest P60 together with copies of your payslips for the period of three months prior to your incapacity.**

5. What benefits in kind did you receive in the 52 weeks immediately prior to the period of incapacity as shown on HM Revenue & Customs form P11D?

- **Please ensure you enclose a copy of your latest P11D.**

6. If you were a full-time working Director in a limited company with no more than 4 shareholders, what dividends representing your share in the net trading profit of that company from its normal, regular business in the 52 weeks before incapacity did you receive?

£

Date Paid

- **Please ensure you enclose a copy of the last three years company accounts, together with the relevant self-assessment tax returns.**

7. a) Have you received any other income from this employment, or any other, since you stopped work because of your current incapacity? You should include any continuing salary, commission, share of net-profit from a business, or any continuing benefits in kind and dividends as above. If Yes, please provide full details to include:

Yes ☐ No ☐

Source of income

Gross Income Net Income

Amount per week £ £

Starting date Ceasing date

b) Do you expect these incomes to alter, or do you expect to receive any other income in future?

Yes ☐ No ☐

If Yes, please provide full details, together with appropriate documentary evidence. (e.g. payslips, dividend statements, company accounts etc.)

Part 2: I am self-employed

1. Please provide the following details about your business:

Full name

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

FAILURE TO GIVE ACCURATE AND COMPLETE INFORMATION MAY RESULT IN NON PAYMENT OF A CLAIM

Full postal address

Town:

County: Postcode:

Telephone number Including STD code)

Type of business

No of partners No of employees

2. What is your tax reference?

3. Please provide the address of the HM Revenue & Customs Office where your tax returns are submitted.

Full postal address

Town:

County: Postcode:

4. Please provide details of your accountant:

Name of accountancy firm

Contact name

Full postal address

Town:

County: Postcode:

Telephone number (including STD code)

E-mail address

5. On what date does your trading year end for accounting purposes?

6. What was your share of the business's pre-tax profit after deduction of trading expenses (for the purposes of Schedule D Case I and II of the Income and Corporation Taxes Act 1988) to be assessed for Income Tax and agreed by the HM Revenue & Customs during the 52 weeks before incapacity? £

- **Please ensure you enclose a copy of all HM Revenue & Customs documentation confirming the latest earned income figure agreed by them, together with a copy of your most recent business accounts.**
- **If you are a partnership, please include a copy of your most recent partnership agreement.**

7. Has your business ceased? Yes No If Yes, from what date?

If applicable, please indicate when the cessation accounts will be available.

If No, who is keeping the business operating in your absence?

If your business is continuing, please detail any **additional** expenses incurred in maintaining your business or any other business as a result of your incapacity. Do not include **normal** ongoing business expenses.

Amount per week £

Nature of the additional expense

Starting date Ceasing date

8. In percentage terms, how has the net profitability of your business been affected by your incapacity, if at all. %

9. a) Have you received any other income since you stopped work? (You should include any continuing commission, share of net-profit from this or any other business). If Yes, please provide full details to include: Yes No

Source of income

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

	Gross Income	Net Income
Amount per week	£	£
Starting date		Ceasing date

b) Do you expect these incomes to alter, or do you expect to receive any other income in future? If Yes, please provide full details, together with appropriate documentary evidence.

Yes ☐ No ☐

Part 3: I am a contract worker

1. Please give details of your Agency(ies):

Name of the Agency		
Full postal address	Town: County: Postcode:	Town: County: Postcode:
Telephone number (including STD code)		
Contact name		
E-mail address of contact name		

2. If you became incapacitated whilst in a contract please provide details of your employer/s:

Name of employer		
Nature of employer's business		
Full postal address	Town: County: Postcode:	Town: County: Postcode:
Telephone number (including STD code)		
Contact name		
E-mail address of contact name		
Start date of the contract		
End date of the contract		

- **Please ensure you enclose a copy of the contract/s.**

3. If you became incapacitated after finishing a contract, but had a future contract secured, please provide details of both your last employer and your future employer:

	Last employer	Future employer
Name of employer		
Nature of employer's business		

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

Full postal address	Town: County: Postcode:	Town: County: Postcode:
Telephone number (including STD code)		
Contact name		
E-mail address of contact name		
Start date of the contract		
End date of the contract		

- **Please ensure you enclose a copy of the contract/s.**

4. What is your tax reference?

5. Please provide the address of the HM Revenue & Customs Office where your tax returns are submitted.

Full postal address	Town: County:	Postcode:

Section F: Other Income During Incapacity

State Benefits

1. What benefits have you received since you first stopped work as a result of your current incapacity?

	Gross per week	Net per week	Start date	End date
a) Statutory Sick Pay (from your employer)	£	£		
b) Incapacity Benefit	£	£		
c) Employment and Support Allowance	£	£		
d) Jobseeker's Allowance	£	£		
e) Any additional Allowances	£	£		
f) Any other State Benefits or Credits*	£	£		

* (Please specify type of Benefit, Allowances or Credits

If you have not yet received any benefit do you expect to do so in the future? Yes ☐ No ☐

NB: Most claimants are entitled to some form of benefits as a result of their incapacity and we are required to take this into account in the financial assessment of a claim. We cannot take into account whether or not you choose to claim benefit. For more information on your entitlement to benefit please contact your employer or your local Jobcentre Plus direct. Alternatively you can apply online at their website: **www.jobcentreplus.gov.uk/JCP/Customers/WorkingAgeBenefits**

Please send us a copy of any correspondence you may have from the Jobcentre Plus, even if they have advised you are not entitled to benefit.

Other Insurances

2. Do you hold any other insurances against incapacity (including Permanent Health Insurance/Income Protection Insurance, Personal Sickness and Accident policies, Mortgage Protection, Loan Protection, Credit Card Protection, Locum Insurance and Waiver of Premium/Contribution Insurance)? **(You should include all policies whether or not benefit has yet been paid)**. If Yes, please provide the following details in respect of each policy: Yes ☐ No ☐

	Policy 1	Policy 2
Name of insurer		
Name of person dealing with the claim		

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

Full postal address	Town: County: Postcode:	Town: County: Postcode:
Telephone number (including STD code)		
E-mail address		
Policy Number		
Claim Number		
Deferred period		
Amount of benefit per week	£ pw	£ pw
Benefit type		
How long is benefit payable for?		

Please provide copies of any copy correspondance from your insurers. I attach copy correspondence. ☐

Pension

3. Are you in receipt of, or have you applied for, a pension? If Yes, please provide the following details: Yes ☐ No ☐

Type of pension (standard/early retirement/ill health)			
Name of pension provider			
Full postal address	Town: County: Postcode:		
Telephone number (including STD code)			
Pension reference number		Date pension payable from	
Amount of pension (please show figures gross and net of Income Tax)	Gross £ per month/per annum	Net £ per month/per annum	

Please provide copies of any copy correspondance. I attach copy correspondence. ☐

Section G: Payment Details

If we agree to pay your claim, we would like to make payments direct to your bank account to ensure you get the money as early as possible. If you would like to take advantage of this service, please provide details of your bank or building society account. Please note the first payment will always be made by cheque.

NB: The account must be in your name.

Bank/Building Society name			
Full postal address	Town: County: Postcode:		
Account holder's name		Account number	
Sort code		Building Society roll number	

☐ **Please tick if any answers relating specifically to the questions on this page are continued on a separate sheet**

Section H: Financial Crime

To verify your identity and prevent financial crime, your information may be used by any company within the Aviva group and may be shared with third parties who provide services to us, as well as other organisations where required to by law and regulatory requirements.

A record may be kept of any searches carried out and any suspicions of financial crime and related details may be retained and used to assist other companies for verification and identification purposes. The search is not a credit check and your credit rating should not be affected.

Section I: Data Protection

Use of personal information

We'll use the information you give us to:

- process and/ or underwrite your application
- decide if we can offer cover and on what terms
- administer your policy and handle any claims
- help detect and prevent fraudulent activity.

Other companies from across the Aviva group, or third parties who provide services to us, in any country (including those outside the European Economic Area) could also use your information in this way. If they do, we'll make sure they agree to treat your information with the same level of protection as we would.

We may share your information with regulatory bodies, other insurers (directly or using shared databases), your insurance intermediary, or third parties providing services to them.

To keep our products and services competitive and suitable for customers' needs, we may also use your information for research and customer profiling.

By signing this form I consent to this use of my personal data as set-out above.

From time to time, we may tell you about other products or services which may be of interest.

I do not wish you to contact me by:

Post ☐ Phone ☐ Email ☐

You can change your mind at any time by contacting us - Aviva, NPE Dept, PO Box 582, Bristol, BS34 9FX.

I hereby authorise Aviva to discuss all aspects (including all medical, financial and any policy details) of my claim with:

Name of other person:	
Relationship to claimant:	Date of birth of other person:
Signature of claimant:	
Signature of other person:	Date:

FAILURE TO DISCLOSE RELEVANT INFORMATION MAY RESULT IN NON PAYMENT OF A CLAIM

PLEASE CHECK THAT ALL YOUR ANSWERS ARE CORRECT AND THAT NOTHING HAS BEEN OMITTED. ANY FURTHER INFORMATION THAT YOU FEEL MAY BE HELPFUL SHOULD BE PROVIDED ON A SEPARATE SHEET. PLEASE COMPLETE THE DECLARATION AND CONSENT BELOW.

DECLARATION and CONSENT by the claimant (not to be signed until the form has been completed)

I hereby declare that I am the claimant referred to in this claim form and that I have read over the replies to all the questions in this form, that to the best of my knowledge and belief all the information given is true and that I have not withheld any relevant information. I shall inform Aviva immediately of any change in my work, medical or financial situation described in the replies given. This includes performing any work, whether paid or unpaid. I understand and accept that if I fail to disclose relevant information known to me or give false information, Aviva is entitled to decline my claim and cancel the policy.

I have read the explanation of my rights in the Access to Medical Reports leaflet, which accompanied this form. I consent to Aviva seeking information about me, to include copies of my full medical records, from any medical practitioner, hospital, specialist, counsellor or similar, and I authorise the giving of such information. I also consent to Aviva seeking information about me from any other source it deems relevant to the consideration and investigation of this claim, including for example HM Revenue & Customs, Department for Work and Pensions, any other insurer, reinsurer or accountant, and I authorise the giving of such information. I understand that such information and the information I provide during the course of this claim, may be passed by Aviva to a third party, e.g. medical examiner, rehabilitation specialist or reinsurer.

I agree to Aviva passing any independent medical examination report and associated tests to my own doctor.

I also agree that Aviva, or a representative appointed by them to act on their behalf, may share information about me (including medical and financial information), with my employer, either by telephone or in writing, in connection with this claim for benefit.

I do not require to see any medical report before it is issued (please delete this sentence if you wish to see reports before they are sent to Aviva).

Signature of Claimant:	Date:
Print Name of Claimant:	

PLEASE NOW FORWARD THIS CLAIM FORM TO AVIVA IN THE ENVELOPE PROVIDED TOGETHER WITH:

1. **A JOB DESCRIPTION, IF AVAILABLE**
2. **FURTHER DETAILS OF CONSULTATIONS, IF APPLICABLE**
3. **FURTHER DETAILS OF OTHER EMPLOYMENT, IF APPLICABLE**
4. **EVIDENCE OF INCOME AS DETAILED IN SECTION E**
5. **DETAILS OF FURTHER INSURANCES, IF APPLICABLE**

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