DEFK0502

Group Income Protection Employee claim form

Your employer would like to submit a claim to us about your absence from working on either a full-time or part-time basis.

What you need to do

Please complete the following forms and send them back to us via your Employer

- Claim form
- 1st copy of the consent form

2nd copy of the consent form should be completed and given to your GP with the request for copies of medical records. Please fill in your details before you give this to your GP.

The **Statutory Rights leaflet** is for you to keep, it gives you information on how we will hold and process your information.

So we can assess the claim effectively, please answer the questions in this form in full and as accurately and honestly as you can. If you have any questions or need help completing any part of the form, please call us on 01306 87 3243 and we will be happy to help.

If you would like additional information about our claims process, please visit our website www.unum.co.uk and look for UP2214 'Employee Guide to Claims Management' in the downloads section, or by using the search function.

Your details

Your employer's name

Your title and name

Your address

Postcode

Your home telephone

Mobile

Your email address

Date of birth

Please leave this space blank

Your medical condition

1. Date that you became unable to work?

2. Please describe your illness or injury, including details of your diagnosis, current symptoms and how often you experience them?

3. Name and address of your GP

Postcode:

Telephone number

Date last consulted

Date of next appointment

Name and address of your main consultant or specialist (please write NONE if no other doctor consulted)

Postcode:

Telephone number

Date last consulted

Date of next appointment

Please use additional pages to provide details of any other consultants/specialists if necessary. If you have copies of any reports or correspondence you think may help us assess the claim, please send them with the claim form.

Your work

1. How does your condition and its symptoms affect your ability to do your job or any other work?

2. What assistance would you need, and what would need to change, for you to return to work?

3. Have you discussed any of these changes with your employer? Yes No

4. Are you doing or planning to do any work, whether for your employer or elsewhere? Please tell us if you do any work, whether paid or unpaid as this may affect our benefit. Yes No

Your home situation and daily activities

1. Are you currently allowed to drive? Yes ☐ No ☐
   If no, please state why and indicate if you have informed the DVLA.

2. What are your current difficulties when carrying out daily activities and how does this affect your day to day living - eg. What can you not do, or you struggle to do, due to your illness or injury that you used to be able to do.

3. Please describe a typical day since the start of your absence due to your condition (from waking to going to bed).

Financial information

1. Have you applied for or are you receiving any benefit under any other sickness, accident or Income Protection policies? Yes ☐ No ☐

   If yes, please provide details below.

Insurer's details, address and phone number	Type of insurance	Policy number	Annual benefit (£)	How long benefit is paid for

2. What income are you currently receiving (from your employer or any other source)? Please provide details below.

Details of what the income is for	Date this income was first received	Monthly/annual amount (£)

Declaration

1. I have read and understood my statutory rights as set out in the accompanying document entitled "Your Statutory Rights".
2. I consent to Unum holding and processing personal sensitive data about me for the purposes of assessing this claim.
3. I declare that all statements made are true and complete to the best of my knowledge and belief and that I have disclosed all information material to this claim for benefit.
4. I agree to let Unum know about any changes in my personal circumstances that might affect this claim.
5. I understand that if any information provided is found to be deliberately misleading, or if I fail to provide material information, this claim may be rejected.
6. I will attend an Independent Medical Examination with a health professional appointed by Unum if requested to do so for the purpose of assessing this claim.

Signed

Date signed (dd/mm/yyyy)

Full name

Please remember to include copies of any reports or correspondence you may have to help us assess the claim.

If you want to provide any additional information, please use this space

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