AGENDA ITEM 10
REPORT NO. VAL/22/19

THE HIGHLAND & WESTERN ISLES VALUATION JOINT BOARD

Personal Accident Insurance

Document Control

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1.0	First release	M Thomson	15/10/19

Introduction

Board staff shall be covered by a Personal Accident Insurance Scheme on the basis that the benefits on death arising out of and in the course of employment including commuting to and from work be set at 5 x annual salary, with other benefits and conditions as summarised below.

Personal Accident Insurance Cover

The Board Scheme for all staff is framed in the following terms:-

Cover

Accidents of Occupation only including bodily injury sustained by the insured Person arising out of and in the course of his/her employment including commuting to and from work.

Benefits

Death	5 Times Salary
Loss of Limb or Sight	5 Times Salary
Permanent Total Disablement	5 Times Salary
Permanent Partial Disablement	% of Capital Sum
Temporary Total Disablement	Benefits paid to the Board for up to 24 months depending on length of service. Salary will be paid to employee for up to 24 months less payment made by the Board's Statutory Sick Pay Scheme.

Exclusions

There are a number of exclusions under the policy, e.g., use of drugs or intoxicants and other exclusions normal to Personal Accident policies.

Claims Procedure

Employee completes personal accident form this can be accessed at Appendix 1.

The certificate on the form must be completed by a GP.

Completed form and medical certificate(s) should be returned to Insurance and Risk Section, Finance Service, Glenurquhart Road, Inverness, IV3 5NX.

Following confirmation from insurers that it is a valid claim Payroll will be notified to reinstate salary payments.

22 November 2019
Annex 1

ZURICH MUNICIPAL

PERSONAL ACCIDENT REPORT FORM

PLEASE ANSWER EVERY QUESTION. **PLEASE REPLY TO:**

Policy Number		Claim Number		**Service**	

INSURED

Name:	**Highland & Western Isles Valuation Joint Board**		
Address:	**Moray House, 16-18 Bank Street,**		
Inverness		Post code	**IV1 1QY**
Telephone Number:	**(01463) 703311**	Occupation:	Gross Salary: £

INJURED PERSON

Name:		D.O.B:
Private Address:		
Pay Number:	Start date with Valuation Joint Board:	National Insurance No:

ACCIDENT

When did accident occur?	Date	Time	am/pm
Where did accident occur?			
How did accident happen?			
What were you doing at the time?			
Give names and addresses of all witnesses of the accident			

INJURIES

State as fully as possible what injuries you have sustained:	
Have you had an injury to the same part before?	If so, give details:

Give name and address of medical practitioner attending you for the injuries:	
Is he/she your usual Medical Attendant?	If not, state what he/she is in attendance:

INCAPACITY

Have you as the direct result of the accident been totally incapacitated from attending to business of any kind?					
If so, give date total incapacity commenced:					
During what period have you been confined to:					
Bed:	From:	To:	House:	From:	To:
Are you now able to attend to any portion of your business?					Date:
When and where can you be visited by our Doctor or other representative?					

The Insured must arrange at their own expense for the completion of this certificate by a qualified and registered Medical Practitioner. **To comply with the "Access to Medical Reports Act 1988", the certificate should be returned to the injured person before being sent on to the company at the address overleaf.**		
Re: (patient's name)		
When did you first attend the patient in respect of his/her accident?		
Are you still in attendance?	Are you the patient's usual Medical Attendant?	
If so, for how long has he/she been your patient?		
State in detail the nature and extent of injuries (if limb injured state whether left or right)		
Are the symptoms from which the patient suffers due to:	(a) The accident only?	(b) Any other cause?
Is the patient now, or was he/she at the time of the accident, subject to or suffering from any illness irrespective of the injuries?		
If so, state the nature of same and the extent to which recovery of patient from the accident may be affected hereby.		
Are you aware of any past accident or illness, which directly or indirectly may have contributed to or may retard the patient's recovery?		
Have you any reason to believe the patient was not sober at the time of the accident?		
Is the patient confined to bed or residence on your instructions?		
If so, what is likely to be the probable period of total incapacity?		
Doctors Signature:	Date:	
Doctor's Name:	Qualifications:	
Doctors Address:		