INCOME PROTECTION

Claim Form for the Self-Employed

Before you give us your personal information it is important that you know what your data protection rights are and how and why we use your personal information. This is set out in the Irish Life Data Privacy Notice which is always available on our website at **http://www.irishlifecorporatebusiness.ie** or you can ask us for a copy. We need personal health information to assess this claim. We may need to contact you if we need to clarify any information or ask you for further information. We may also need to get personal health information in connection with this claim from Doctors, GPs, consultants, hospitals or other health professionals. We may use the health information obtained at this claim for any of your subsequent claims to Irish Life.

Irish Life provides a home visit service and an appointment may be made by a Health Claims Advisor to meet with you to discuss your claim. If such a meeting is arranged, any information provided by you together with any observations made by the Health Claims Advisor will form part of your claim data.

In certain circumstances we will use the service of Licenced Private Investigators. Each Licenced Private Investigator must adhere to a strict code of practice and complete a compliance certificate. They are expected to comply at all times with the Data Protection Law and not perform their functions in such a way as to cause Irish Life to breach any of its obligations under Data Protection Law. Any unauthorised processing, use or disclosure of personal data by Private Investigators is strictly prohibited. If you wish to appoint a third party to act on your behalf in relation to this claim please contact us on 01 704 1802.

If you are an Employed Person do not complete this form. Please ring your Insurance Broker or Irish Life directly for the appropriate form.

Please read every question carefully and complete every item on this form in BLOCK CAPITALS.

If any item is blank or illegible, this may cause a delay in processing your claim. If you are unsure about any item, you should ask your plan adviser. This form must be fully completed and returned to the Income Protection Claims Team, Irish Life, no later than 2 calendar months before the end of the deferred period. Details of your deferred period will be in your plan booklet. A Medical Certificate must also be furnished without expense to Irish Life. The issue of this claim form is in no way an admission of liability. Please provide as much information as possible. This will enable us to process the claim quickly.

Warning: Providing false information on this form could result in your claim being terminated and all cover being cancelled.

Section 1: Personal Details

Name of Business

Policy Number

Name of Claimant

Home Address

Phone Home Mobile

Email Address

Date of Birth Male ○ Female ○

Relationship Status Married ○ Single ○ Widow(er) ○ Separated ○ Divorced ○ Civil Partner ○

Name of Employer

PPS Number

PPS Number should contain 7 digits and 1 or 2 letters. This is required for Revenue Approval.

Business Address

Business Phone Number

Business Mobile Number

Bank Account Details

Payment of the pension, must be to a bank, building society or Credit Union (via the Credit Union bank account)

Bank Account Number (IBAN)

Swift Bic

Name/Names of Account Owners

Bank Name

Bank Address

Bank Account Details will only be used if, following assessment, a decision is made to admit the claim and a payment is due. If the payment is being made to your personal bank account, a copy of a recent bank statement header showing your address, the IBAN and BIC is required.

Please note that we will require the following for identification:

- A valid, unexpired fully legible copy of photo identification (e.g. passport or driver's licence) and
- A fully legible copy of current address identification (e.g. recent utility bill or statement – dated within the last 6 months).
- To pay by bank transfer we we will need a copy of the header of a recent bank statement showing the IBAN and BIC of the account along with the account holder's name.

Have you enclosed appropriate forms of ID? Yes ◯ No ◯

Section 2: Occupation Details

1. How long have you been Self-Employed?

2. a) Are you engaged on your own account as a sole trader Yes ◯ No ◯

   b) Are you a partner personally acting in some trade, profession or occupation? Yes ◯ No ◯

3. Are any family members involved in the business? If yes, please give details to include the exact nature of their involvement. Yes ◯ No ◯

4. What was your precise occupation(s) immediately prior to disablement?

5. Please describe your normal duties in detail.

6. Please confirm if your job involves any of the following?

   a) Walking Yes ◯ No ◯ hours per day

   b) Standing Yes ◯ No ◯ hours per day

   c) Bending Yes ◯ No ◯ hours per day

   d) Sitting Yes ◯ No ◯ hours per day

   e) Climbing (i.e. ladders/stairs) Yes ◯ No ◯ hours per day

   f) Lifting Yes ◯ No ◯ hours per day

   Max weights lifted

   Average weights lifted

g) Driving Yes ◯ No ◯ hours per day

Mileage per annum Vehicle type

7. Please advise whether any special licences are required for you to carry out the occupation.

8. Are any special skills required? If yes, please give full details. Yes ◯ No ◯

9. What specific tools/equipment would you normally use?

10. In what environmental conditions would you normally expect to be working? (e.g. office, factory, any extremes of heat or cold, outdoors etc).

11. How many hours would you normally expect to work during the week? hours per week

12. Does the job involve any unsocial hours? If yes, please give full details. Yes ◯ No ◯

13. Do you supervise any other staff? Yes ◯ No ◯ If yes, how many? Number of Staff

14. Please provide details of any qualifications you have obtained or courses you have attended in relation to this job or any other occupation.

15. Please provide full details of your job history.

16. Is the business still trading? Yes ◯ No ◯

If no, please confirm the exact date on which the business ceased trading

17. Have you incurred any additional staff costs due to your current disability? If yes, please give full details. Yes ◯ No ◯

18. Have you made any plans to resume your normal occupation? If yes, please advise when you expect to do so. full details. Yes ◯ No ◯

Section 3: Financial Details

Name of Accountant

Accountant's Address

Phone Number

Mobile Number

a) Provide copies of your accounts and copies of income tax assessments in respect of the 3 years immediately prior to disablement. If the accounts and/or income tax assessment for the most recent year have not yet been prepared, please ask your Accountant to confirm in writing when these will be available.

b) Confirm in writing whether or not you are currently receiving any income from the business since your disability began.

Please note we will not be in a position to consider your claim without this information.

Please complete this section if your disability is as a result of an accident

Section 4: Accident Details

1. Please describe where the accident occured.

   Date of accident

2. Please describe the exact nature and cause of the accident.

To be completed by all claimants

Section 5: Medical Details

1. Please describe in detail below the condition or disability which you are currently suffering from?

2. What was the nature of the initial symptoms and when did they first occur?

3. Exact date on which you stopped working?

4. Are you restricted by your disability? If yes, please describe below how you are restricted. Yes ◯ No ◯

5. What medication are you currently taking? Please include dosage.

6. Are you having any non-drug therapy? e.g. physio, counselling or alternative medicine. Yes ◯ No ◯
If yes, please give details and names and addresses of practitioners.

7. Are you using any physical aids e.g. walking sticks or collars? If yes, please give full details. Yes ◯ No ◯

8. Is your current treatment providing any relief of symptoms? If yes, please give full details. Yes ◯ No ◯

9. Has there been any improvement in your condition? If yes, please give full details. Yes ◯ No ◯

10. Have you had discussions with your General Practitioner (GP) or Consultant regarding returning to the workforce? f yes, please give full details, including the type of work you are interested in performing. Yes ◯ No ◯

Section 6: Medical Attendant Details

Please list the full names and addresses of all doctors/specialists who are currently treating you (or who have treated you in the past for these problems).

Name and Address of Speciality of Doctor/Consultant	Date last attended	Next Appointment

Section 7: Hobbies and Pastimes

1. What are your present hobbies or pastimes?

2. Are you able to continue with these? Yes ◯ No ◯

3. Have you developed any new interests since your disability began? If yes, please give full details. Yes ◯ No ◯

Section 8: Previous Disablement

1. Have you previously suffered from the above disablement or any other sickness or injury for more than 4 weeks?If yes, please give full details with approximate dates and periods of incapacity. Yes ◯ No ◯

Section 9: Employment Since Disability

Please Note: The policy conditions provide for a reduced benefit to be paid in certain circumstances. Examples of these circumstances could include your return to your normal occupation on a part-time basis or taking up an alternative occupation at lower earnings. **However, it is extremely important that you notify Irish Life in advance if you do so, as failure to disclose this information could result in your claim being rejected and all cover ceasing**. Please ring Income Protection Claims in Irish Life on 7041802 if you require any further details.

1. Since your disability began, have you:

   a) Undertaken ANY of the duties of your normal occupation? Yes ◯ No ◯

   b) Undertaken ANY other work (whether paid or not)? Yes ◯ No ◯
   If you have answered yes to either of the above, please confirm the following:

   c) Exact nature of work performed

   d) Date of commencement

   e) Hours worked per month hours per month

   f) Monthly Earnings €

   g) Name of employer

   h) Are you still working? Yes ◯ No ◯ If no, when did you stop?

2. If you have been unable to undertake any work whatsoever, please advise when you anticipate that you may be able to do so?

Section 10: Other Benefits

Are you insured against accident or sickness with any other insurance company (including mortgage disability policies)?If yes, please confirm the following: Yes ◯ No ◯

Name of Company

Policy Number Yearly amount of benefit € per year

Start date of policy Start date of benefit

Deferred period

Section 11: Previous Claims

Have you previously had a disablity claim with Irish Life or any other company? If yes, please give details. Yes ◯ No ◯

Section 12: Awards

1. Are you currently pursuing a third party claim in connection with this disablement? Yes ◯ No ◯
2. If yes, please advise:
   a) Date proceedings issued
   b) Date employer/third party notified
   c) What stage are proceedings at?

Section 13: Social Welfare Benefits

Are you entitled to any social welfare benefits? Yes ◯ No ◯

If so, are you currently in receipt of any benefits? Yes ◯ No ◯

Please list each type of benefit and weekly amount individually

€ weekly

€ weekly

€ weekly

Have you been required to attend for medical assessment by the Department of Social & Family Affairs medical referee? If yes, what was the outcome? Yes ◯ No ◯

If yes, please provide the date of the examination

If no, is an examination planned? Yes ◯ No ◯

If you have not been medically approved for benefit by the Department of Social & Family Affairs, are you appealing this decision? If yes, please provide full details. Yes ◯ No ◯

Section 14: Additional Information

Please state any additional information which may be of assistance in the ongoing management of this claim.

Section 15: Data Privacy Notice and Employee Declaration

Data Privacy Notice

I confirm I have been informed about the Irish Life Data Privacy Notice and where to find it.

I declare that

I declare that I have answered questions in this claim form in an honest and reasonably careful manner, and the information given in this form, is true and complete and i am the person referred to in the particulars given. I understand that if i provided false or deliberately inaccurate information on this form my cover may be canceled. I understand that Irish Life can use my person information for any of my subsequent claims to Irish Life.

I fully understand that i must notify Irish Life immediately, if i resume my normal occupation either on a full time or part time basis, or if I take up any alternative work whether paid or not, as failure to so so could result in immediate termination of the claim and cover ceasing.

I understand and acknowledge that to process my claim Irish Life will seek further information and/or share relevant information, in the context of this claim with:

- Any doctors, GPs, consultants, hospitals or other health professional nominated by Irish Life in relation to the assessment and/or management of my claim or who at any time has attended me concerning anything which affects my physical or mental health. This may include the time prior to my application for cover.
- A Health Claims Advisor if a home visit is arranged. Irish Life provides a home visit service and an appointment may be made by a Health Claims Advisor to meet with you to discuss your claim. If such a meeting is arranged, any information provided by you together with any observations made by the Health Claims Advisor will form part of your claim.
- Any insurance office insuring me for Income Protection or similar benefits whether I have made a claim or not.
- My employer, solicitor, accountant or other similar source which Irish Life deem necessary in relation to the assessment and management of this claim.
- Licenced Private Investigators who Irish Life engage to verify information for any claim.

Please sign and date

Signature Date

Section 16: Authorisation to provide information

I authorise the parties listed below to share information with Irish Life on request from Irish Life:

- Any GPs, consultants, hospitals or other health professionals who has attended me concerning anything to do with my physical or mental health.
- My employer, solicitor, accountant, or other similar source which Irish Life deem necessary in relation to the assessment and management of this claim.

Please sign and date

Signature Date

Name BLOCK CAPITALS

Irish Life Corporate Business, Lower Abbey Street, Dublin 1, Ireland. T: 01 704 2000 • F 01 704 1905

Irish Life