PENSIONS
INVESTMENTS
LIFE INSURANCE

Irish Life

INCOME PROTECTION

CLAIM FORM

Group Policy Number

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.

Please read every question carefully and complete every item on this form in BLOCK CAPITALS. Sections below are to be completed by the claimant. This form must be fully completed and returned to the Income Protection Claims Team, Irish Life, no later than (A) 2 calendar months from the date of commencement of disability if the deferred period is 13 weeks, or (B) 4 calendar months from the date of commencement of disability if the deferred period is 26 weeks, or (C) 8 calendar months from the date of commencement of disability if the deferred period is 52 weeks.(The deferred period for each policy may differ you should obtain details of the deferred period for your policy from your HR department or refer to your plan booklet for more information). 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 to 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 Claimant

Home Address

Email Address

Phone Home Mobile

Claim Number

Date of Birth / / Male Female

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

Name of Employer

Section 2: Occupation Details

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

2. Please describe your normal duties in detail.

3. Please advise whether any special licences or qualifications are required for you to carry out your occupation.

4. Are any special skills or tools needed? If yes, please give full details. Yes ◯ No ◯

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

6. (a) Are you employed on a Permanent or Contract basis? Permanent ◯ Contract ◯

   (b) If on Contract please confirm the duration and expiry date of contract: Duration

   Expiry Date ☐☐ / ☐☐ / ☐☐☐☐

7. What are your standard working hours per week? hours per week

8. Are you contracted to do shift work? If yes, please give full details. Yes ◯ No ◯

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

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

11. Please provide full details of your job history.

12. When were you last in contact with your employer?

13. (a) Have you discussed future employment or rehabilitation with your employer. Yes ◯ No ◯

    (b) If yes, what was the outcome?

    (c) If you have not yet had discussions with your employer, do you have plans to do so and if so, when? Yes ◯ No ◯

14. Is your position still available for you to return to? Yes ◯ No ◯

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

16. Are you currently in receipt of sick pay? Yes ◯ No ◯ If yes, how much? €

    When is it due to cease? ☐☐ / ☐☐ / ☐☐☐☐

Section 3: Accident Details (please complete this section if your disability is as a result of an accident)

1. Please advise place of accident

   Date of accident ☐☐ / ☐☐ / ☐☐☐☐

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

Section 4: 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. Have you discussed returning to your previous job with your GP or Specialist? If yes, please give full details. Yes ◯ No ◯

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

11. In relation to any physical disability, please confirm if your job involves any of the following?

(a)	walking	Yes ◯	No ◯	hrs per day		
(b)	standing	Yes ◯	No ◯	hrs per day		
(c)	bending	Yes ◯	No ◯	hrs per day		
(d)	sitting	Yes ◯	No ◯	hrs per day		
(e)	climbing (i.e. ladders/stairs)	Yes ◯	No ◯	hrs per day		
(f)	lifting	Yes ◯	No ◯	hrs per day	Max. wts. lifted	Avg. wts.lifted
(g)	driving	Yes ◯	No ◯	hrs per day	Mileage p.a.	Vehicle type
(f)	working at heights	Yes ◯	No ◯	Details		

Section 5: 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, Address and Speciality of Doctor/Consultant	Date last attended	Date last attended	Date of next appointment
	/ /	/ /	/ /
	/ /	/ /	/ /
	/ /	/ /	/ /
	/ /	/ /	/ /

Section 6: 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 7: Previous Disablement

Have you previously suffered from the above disablement or any other sickness or injury for more than 4 weeks? Yes ◯ No ◯

If yes, please give full details with approximate dates and periods of incapacity.

Section 8: 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 hrs per mth

   (f) Monthly Earnings € (g) Name of employer

   (h) Are you still working? Yes ◯ No ◯ (d) 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 9: Other Benefits

Are you insured against accident or sickness with any other insurance company (including mortgage disability policies)? Yes ◯ No ◯

If yes, please confirm the following:

Name of Company

Policy Number

Yearly amount of benefit € per year

Start date of policy __ __ / __ __ / __ __ __ __

Start date of benefit __ __ / __ __ / __ __ __ __

Deferred period

Section 10: Other Disability Claims

Have you previously had a disablity claim with Irish Life or any other company? If yes, please give details.

Section 11: 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 12: 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

	€ /wk
	€ /wk
	€ /wk

Have you been required to attend for medical assessment by the Department of Social & Family Affairs medical referee? Yes ◯ No ◯

If yes, what was the outcome?

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 13: Additional Information

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

Section 14: Declaration

I declare that to the best of my knowledge and belief, the information given in this claim form, is true and complete and that I am the person referred to in the particulars given. I understand that if I provide false or deliberately inaccurate information on this form my cover may be cancelled. I understand that Irish Life can use my personal 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 do so will 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.

✍ Signature ✗ Date / /

Irish Life Assurance plc is regulated by the Central Bank of Ireland.
In the interest of customer service we may record and monitor calls. Irish Life Assurance plc, Registered in Ireland number 152576, Vat number 9F55923G.

Section 15: 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.

✍ Signature ✗ Date / /

Name (Block Capitals)

Irish Life Assurance plc is regulated by the Central Bank of Ireland.
In the interest of customer service we may record and monitor calls. Irish Life Assurance plc, Registered in Ireland number 152576, Vat number 9F55923G.

CONTACT US

PHONE: 01 704 2000
FAX: 01 704 1905
EMAIL: code@irishlife.ie
WEBSITE: www.irishlifecorporatebusiness.ie
WRITE TO: Irish Life Corporate Business, Irish Life Centre, Lower Abbey Street, Dublin 1.

Irish Life Assurance plc is regulated by the Central Bank of Ireland.
In the interest of customer service we will monitor calls.
Irish Life Assurance plc, Registered in Ireland number 152576, VAT number 9F55923G.

3599cb (Rev 5-18) standard ID

Irish Life