INCOME PROTECTION CLAIMS

Employment Information 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.

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, together with a Claim Form completed by the claimant.

Please provide a birth certificate with this form (a copy will suffice). A Medical Certificate must also be furnished without expense to Irish Life. The issue of this form is in no way an admission of liability.

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.

Section 1: Claim Details

Scheme Name

Name of Employer

Address

Email Address

Phone Home Mobile

Group Policy number

Name of Claimant

Job Title

Date of Birth

Exact date of ceasing work

Date of joining service

Date of joining Income Protection Plan

Section 2: Job Details

1. Is a detailed job description available? If yes, please enclose a copy with this form. Yes ◯ No ◯
2. If a written job description is not available, please describe the occupation in detail below.

3. a. Is the claimant 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
   c. If on permanent basis: Full-time ◯ Part-time ◯
   d. What are their standard working hours per week? hours per week
   e. Is there a requirement for overtime? Yes ◯ No ◯ hours per week

Please tick and give details

4. Does the employee's job involve 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. Cimbing Yes ◯ No ◯ ____ hours per day

f. Lifting Yes ◯ No ◯ ____ hours per day

____ maximum weights lifted ____ average weights lifted

g. Driving Yes ◯ No ◯ ____ hours per day

____ Mileage per annum ____ Vehicle type

h. Working at heights Yes ◯ No ◯ ____ hours per day

Details ____

5. Are any special licences or qualifications required for the employee to carry out the job? Yes ◯ No ◯
If yes, please give full details.

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

7. Does the job require a degree of manual dexterity? If yes, please outline below the full extent and range of dexterity required. Yes ◯ No ◯

8. In what environmental conditions would they normally work? (eg office, factory, any extremes of heat or cold, outdoors etc).

9. Is the employee required to operate machinery? If yes, please give full details. Yes ◯ No ◯

Section 3: Employment Details

1. What was the claimant's exact salary on the following dates?

a. Renewal date immediately preceding date of disablement € ____ Annual Salary

b. Date of disablement (ie date of ceasing work) € ____ Annual Salary

2. Is the employee still in receipt of sick pay? Yes ◯ No ◯

If yes, monthly amount € ____ How long will this be paid for? ____

If no, when did it cease? ____

3. Is their job still available on recovery? Yes ◯ No ◯

4. Has the claimant performed any work since becoming disabled? If yes, please outline the exact nature of duties performed together with earnings received. Yes ◯ No ◯

5. Is the claimant still an employee of the Company? If not, when was he/she issued with a P45? Yes ◯ No ◯

6. Do you keep in regular contact with the claimant? Yes ◯ No ◯

7. When did you last have a discussion with the claimant concerning his/her disability?

8. Have you had any recent discussions with the claimant regarding returning to work? If yes, what was the outcome? Yes ◯ No ◯

9. If you have not had any recent discussions do you intend on doing so in the near future? If yes, please confirm when you are planning to do so? Yes ◯ No ◯

10. Do you have an occupational health nurse or doctor? Yes ◯ No ◯

    If yes, do they keep in regular contact with the employee? Yes ◯ No ◯

    Please advise exact date(s) and outcome of last consultation(s) and details of any future appointments.

11. Do you have an Employee Assistance Programme? If yes, has the employee availed of this? Yes ◯ No ◯

12. Is the Company in a position to facilitate a phased return to work (if medical evidence supports this) with a view to the claimant eventually resuming full-time work? If no, please outline below the reasons why this is not possible. Yes ◯ No ◯

13. If medical evidence confirms the claimant is unfit to resume his/her normal occupation indefinitely would the Company consider an offer of alternative employment (depending on medical evidence and the fitness of the claimant to do the alternative job)? If yes, please outline below the alternative occupations that could be offered by the Company to the claimant. Yes ◯ No ◯

Section 4: Other Claims

1. Is the claimant currently pursuing an employer's liability or third party claim in connection with this disablement? If yes, please give full details. Yes ◯ No ◯

2. Has the claimant been considered for early retirement under the pension scheme? If yes, please give full details. Yes ◯ No ◯

Section 5: Social Welfare Benefits

Please list each type individually

Is the claimant entitled to Social Welfare benefits? If yes, please confirm type and amount of benefit? Yes ◯ No ◯

Section 6: Additional Information

Additional information, if any, relating to the claimant and his/her disability.

Section 7: Electronic Fund Transfer

In the event of the claim being admitted, payment of benefit will be transferred directly to the employer's Republic of Ireland bank account. Details of the monthly payment lodged will be provided to you by post.

This facility is not available for Sterling claims.

Please confirm the following details

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.

Section 8: 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 to the best of my knowledge, the above statements are true in every respect. I also confirm that the Company wish to have a claim considered in respect of the above employee and paid to the bank details as stated above.

Name

Position in the Company

Please sign and date

Employer's Stamp (if available)

Signed

Date

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Irish Life