INCOME PROTECTION CLAIMS

Claim Form for Group Voluntary Schemes

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. 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 HR Department or 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 (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. 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

Use Block Capitals

Name of Claimant

Home Address

Phone Home Mobile

Email Address

Date of Birth Male Female

Date joined public service

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

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

PPS Number

Business Address

Business Phone Number Business Mobile Number

Bank Account Details

Bank Account Number (IBAN) ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐

Swift Bic ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐

Name/Names of Account Owners

Bank Name

Bank Address

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

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

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

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

10. Please provide full details of your job history.

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

When is it due to cease?

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

12. Have you retired early from your occupation? If yes, please advise. Yes ◯ No ◯

a) Date of early retirement

b) Amount of early retirement pension €

14. If you have not retired early, please advise:

a) Is your position still available for you to return to? Yes ◯ No ◯

b) Have you made any plans to resume your normal occupation? Yes ◯ No ◯

c) Please advise when you expect to resume work

d) Are you planning to retire early at a future date? If yes, please advise:

Expected date of retirement

Exact reasons why you are actively seeking retirement

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

Section 3: 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 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. If yes, please give details and names and addresses of practitioners. Yes ◯ No ◯

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 ◯		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	

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 and Address of Speciality of Doctor/Consultant	Date first attended	Date last attended	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

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 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 hours per month

f) Monthly Earnings €

g) Name of employer

h) Are you still working? Yes ◯ No ◯

i) 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)?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 10: Previous Claims

Please state any additional information which you feel would assist us in assessing your claim.

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

€ 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 13: Additional Information

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

Section 14: 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 cancelled. 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 do 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 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.

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