Income Protection Claims

Claim Form

Group Policy No.

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. 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 rejected and all cover being cancelled.

1. PERSONAL DETAILS

Name of Claimant

Home Address

Telephone Number   Mobile Number

Email Address

Date of Birth dd/mm/yyyy   Male ☐   Female ☐

Civil Status   Married ☐ Single ☐ Widow(er) ☐ Separated ☐ Divorced ☐ Civil Partner ☐ Former Civil Partner ☐

Name of Employer

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 dd/mm/yyyy

2. OCCUPATION DETAILS CONTINUED

7. What are your standard working hours per week? hrs 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? If yes, how many. yes ☐ no ☐

No. 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? € per month When is it due to cease? d d / m m / y y y y

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 d d / m m / y y y y

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

4. MEDICAL DETAILS (TO BE COMPLETED BY ALL CLAIMANTS)

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? d d / m m / y y y y

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 ☐

4. MEDICAL DETAILS CONTINUED

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.
(h) working at heights	yes ☐	no ☐	Details		

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 & Speciality of Doctor/Consultant	Date first attended	Date last attended	Date of next appointment
	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy
	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy
	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy
	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy

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 ☐

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.

8. EMPLOYMENT SINCE DISABILITY

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.

1. Since your disability began, have you:

   (a) Undertaken ANY of the duties of your normal occupation? yes ☐ no ☐

   (b) Undertaken ANY work whatsoever (whether paid or not)? yes ☐ no ☐

   If you have answered **yes** to either of the above, please confirm the following:

   (c) Nature of work performed

   (d) Date of commencement d d / m m / y y y y (e) Hours worked per month hrs per mth

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

   (h) Are you still working? yes ☐ no ☐ If no, when did you stop? d d / m m / y y y y

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

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 d d / m m / y y y y Start date of benefit payment d d / m m / y y y y

Deferred period

10. OTHER DISABILITY CLAIMS

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

11. AWARDS

1. Are you currently pursuing an employers liability or third party claim in connection with this disablement? yes ☐ no ☐

2. If yes, please advise

   (a) Date employer/third party notified? dd/mm/yyyy

   (b) Date proceedings issued? dd/mm/yyyy

   (c) What stage are these at?

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 no, is an examination planned? yes ☐ no ☐ Date of the examination dd/mm/yyyy

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 ☐

13. ADDITIONAL INFORMATION

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

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 also 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 consent to Irish Life seeking information in connection with this claim from any source which Irish Life deem necessary and I authorise the giving of such information.

I consent to Irish Life seeking information from any doctor, who at any time has attended me concerning anything which affects my physical or mental health. I also consent to Irish Life seeking information, including information regarding my physical or mental health, from any insurance office to which a claim has been made by me and I authorise the giving of such information.

Signature | | Date / /

Please also sign the consent form below.

Irish Life may check to establish if an individual has any additional claims with other insurers. This data will be maintained by us in line with the provisions contained in the Data Protection Acts 1988 and 2003.

The information provided to us as part of your claim application will be processed by us to confirm your identity, process your application and to record and cross reference particulars of your claim in insurance industry databases for fraud prevention purposes. In certain cases this may involve the sharing of your information with other insurance providers and private investigators. Guidelines for sharing of information in this regard are contained in a Code of Practice on Data Protection for the Insurance Sector which has been agreed with the Data Protection Commissioner.

Please Note that Irish Life may use private investigators. Each private investigator must adhere to a strict code of practice, and complete a compliance certificate on a yearly basis. They shall be expected to comply at all times with the Data Protection Acts and not perform their functions in such a way as to cause Irish Life to breach any of its obligations under the Data Protection Acts. Any unauthorised processing, use or disclosure of personal data by private investigators is strictly prohibited.

15. CONSENT TO OBTAIN INFORMATION

I consent to Irish Life seeking information in connection with this claim from any doctor who at any time has attended me concerning anything which affects my physical or mental health. I also consent to Irish Life seeking information, including information regarding my physical or mental health, from any other insurance office and I authorise the giving of such information.

Signature | | Date / /

Lower Abbey Street
Dublin 1 Ireland
T: 01 704 2000
F: 01 704 1900

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