

2. OCCUPATION DETAILS CONTINUED

4. Are any special skills or tools required? 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?

hrs 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? If yes, how many.

yes no

 No. 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?

 dd / mm / yyyy

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

13. Have you retired early from your occupation? If yes, please advise:

yes no

(a) Date of early retirement

 dd / mm / yyyy

(b) Amount of early retirement pension

 € p.a.

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.

 dd / mm / yyyy

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

yes no

(i) Expected date of retirement

 dd / mm / yyyy

(ii) Exact reasons why you are actively seeking retirement

3. ACCIDENT DETAILS (PLEASE COMPLETE THIS SECTION IF YOUR DISABILITY IS AS A RESULT OF AN ACCIDENT)

1. Please describe where the accident occurred?

Date of accident / /

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?

/ /

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

4. MEDICAL DETAILS CONTINUED

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 <input type="checkbox"/>	no <input type="checkbox"/>	<input type="text"/> hrs per day		
(b) standing	yes <input type="checkbox"/>	no <input type="checkbox"/>	<input type="text"/> hrs per day		
(c) bending	yes <input type="checkbox"/>	no <input type="checkbox"/>	<input type="text"/> hrs per day		
(d) sitting	yes <input type="checkbox"/>	no <input type="checkbox"/>	<input type="text"/> hrs per day		
(e) climbing (i.e.ladders/stairs)	yes <input type="checkbox"/>	no <input type="checkbox"/>	<input type="text"/> hrs per day		
(f) lifting	yes <input type="checkbox"/>	no <input type="checkbox"/>	<input type="text"/> hrs per day	Max. wts. lifted	<input type="text"/> Avg. wts. lifted
(g) driving	yes <input type="checkbox"/>	no <input type="checkbox"/>	<input type="text"/> hrs per day	Mileage p.a.	<input type="text"/> Vehicle type.

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

6. HOBBIES AND PASTIMES

1. What are your hobbies and 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

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 Third Party notified?

/ /

(c) What stage are proceedings 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 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

13. ADDITIONAL INFORMATION

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



Irish Life

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Irish Life Corporate Business