

Income Protection Claims



Irish Life

Medical Certificate

Please read every question carefully and complete every item on this form in **BLOCK CAPITALS**.

Completion of this certificate is required in order to assess an income protection claim. The benefit payable is usually a percentage of salary and so very substantial amounts can be involved. Full completion of this certificate will result in prompt processing of your patient's claim.

This form must be fully completed and returned to the Income Protection Claims Team, Irish Life. The claimant is responsible for any fee in connection with the completion of this medical certificate. Please provide as much information as possible as this will facilitate prompt assessment of this claim and help avoid the need for further enquiry.

1. CLAIMANT'S DETAILS

Claimant's Name

Date of Birth / /

Employer

Occupation

2. RELATIONSHIP TO CLAIMANT

1. Are you the claimant's usual medical attendant? yes no
If yes, how long?

2. When did you first see the claimant with this incapacity?

3. Are you still attending the claimant? yes no If so, date last seen / /

4. What is the anticipated frequency of future consultations related to this disablement with:
You Any other treating doctors

3. NATURE OF DISABILITY

ICD9

1. Date disability commenced / /

2. What is the exact nature and cause of disability?

3. Please describe the exact nature of symptoms which are preventing your patient from working?

3. NATURE OF DISABILITY CONTINUED

4. Results of all investigations carried out? (Please submit copies of any relevant hospital reports, test results and investigations, as these will speed up the processing of your patient's claim)

5. Are any further investigations/surgery planned? If yes, please give full details below. yes no

6. Is your patient, as a result of their condition, restricted in any of the following?

(a) sitting	yes <input type="checkbox"/>	no <input type="checkbox"/>	Details	<input type="text"/>
(b) walking	yes <input type="checkbox"/>	no <input type="checkbox"/>	Details	<input type="text"/>
(c) standing	yes <input type="checkbox"/>	no <input type="checkbox"/>	Details	<input type="text"/>
(d) bending	yes <input type="checkbox"/>	no <input type="checkbox"/>	Details	<input type="text"/>
(e) climbing (i.e. ladders/stairs)	yes <input type="checkbox"/>	no <input type="checkbox"/>	Details	<input type="text"/>
(f) lifting weights	yes <input type="checkbox"/>	no <input type="checkbox"/>	Details	<input type="text"/>
(g) driving	yes <input type="checkbox"/>	no <input type="checkbox"/>	Details	<input type="text"/>
(h) maintaining concentration	yes <input type="checkbox"/>	no <input type="checkbox"/>	Details	<input type="text"/>

7. Is the patient's condition:

(a) improving?	yes <input type="checkbox"/>	no <input type="checkbox"/>
(b) deteriorating?	yes <input type="checkbox"/>	no <input type="checkbox"/>
(c) static?	yes <input type="checkbox"/>	no <input type="checkbox"/>

8. If the condition is not improving, why is this?

4. TREATMENT

1. Please provide exact details of current treatment.

2. Please advise on the types and effect of previous treatment regimes?

4. TREATMENT CONTINUED

3. (a) Is the treatment providing any relief of symptoms ? If yes, please give full details.

yes no

(b) If no, is a change in treatment currently contemplated? If yes, please give full details.

yes no

4. Does the patient suffer more than minor side effects as a result of their medication? If yes, please give details..

yes no

5. To your knowledge is the claimant fully complying with treatment? If no, please provide full details and how this affects management of the condition

yes no

5. EXTENT OF DISABILITY

1. (a) Is the claimant in your opinion currently able to carry out the duties of his/her normal occupation?

yes no

(b) If yes, please confirm the exact date on which he/she was fit to do so?

(c) If no, what is the expected duration of work absence as a result of this disability:

0 - 3 months? 3 months - 6 months? 6 months - 1 year? 1 year - 3 years? 3+ years?

2. (a) If your patient is currently unfit for his/her normal occupation, what aspects is he/she currently unable to perform?

(b) What aspects is he/she currently able to perform?

3. Is the claimant in your opinion currently fit to resume his/her normal occupation on a part-time basis?

yes no

If yes, please outline below the nature of work and the number of hours per week that could be performed.

4. When in your opinion will he/she be able to resume full time work?

6. REHABILITATION

The policy conditions provide for a reduced benefit to be paid in certain circumstances. Examples of these circumstances could include a return to their normal occupation on a part-time basis or taking up an alternative occupation at lower earnings. This should be financially beneficial to the claimant. With this in mind and with a view to speeding up the rehabilitation process, please advise:

1. (a) Do you feel it is in your patient's best interests to resume work as soon as possible?

yes no

If no, please explain below in detail:

(b) If it would be in your patient's interest to resume work please advise if you have discussed any of the following:

(i) return to own occupation - full-time?

yes no

(ii) return to own occupation - part-time?

yes no

(iii) return to an alternative occupation?

yes no

If yes to any of the above, please give full details of what is possible and what rehabilitation steps are required in order to achieve this.

(c) If you have not yet discussed return to work options with your patient, do you have any plans to do so?

yes no

If yes, please give full details including the approximate date on which you intend to have this discussion with your patient.

7. ADDITIONAL INFORMATION

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

8. OTHER SPECIALISTS

Please list the full names and addresses of all other specialists attended.

Name, Address & Speciality of Doctor/Consultant	Date first attended	Date last attended	Date of next appointment
<input type="text"/>	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy
<input type="text"/>	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy
<input type="text"/>	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy
<input type="text"/>	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy

9. DECLARATION

I certify that I have satisfied myself by personal examination that all foregoing statements are correct.

Please use BLOCK CAPITALS.

Doctor's Name

Address

Qualification

Doctor's Stamp

Signature Date



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Irish Life Assurance plc is regulated by the Central Bank of Ireland.
In the interest of customer service we may record and monitor calls.
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