

Income Protection Claims



Irish Life

Claim Form for the Self Employed

If you are an Employed Person do not complete this form. Please ring your Insurance Broker or Irish Life directly for the appropriate 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. If you are unsure about any item, you should ask 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. 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 rejected and all cover being cancelled.

1. PERSONAL DETAILS

Name of Business

Policy number

Name of Claimant

Home Address

Email address

Telephone Number Mobile Number

Date of Birth / / Male Female

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

PPS number *PPS Number should contain 7 digits and 1 or 2 letters. This is required as Irish Life may be responsible for deducting any tax due on any benefit payable.*

Business Address

Business Tel. Number Business Mobile No

Bank Account No. Bank Sort Code - -

Name/Names of Account Owners

Bank Name

Bank Address

2. OCCUPATION DETAILS

1. How long have you been Self Employed?

2. Are you: (a) Engaged on your own account as a sole trader? yes no
(b) A partner personally acting in some trade, profession or occupation? yes no

3. Are any family members involved in the business? yes no
If yes, please give details to include the exact nature of their involvement

2. OCCUPATION DETAILS CONTINUED

4. What was your precise occupation(s) immediately prior to disablement?

5. Please describe your normal duties in detail

6. 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.

7. Please advise whether any special licences are required for you to carry out the occupation.

8. Are any special skills required? If yes, please give full details.

yes no

9. What specific tools/equipment would you normally use?

10. In what environmental conditions would you normally expect to be working? (eg office, factory, any extremes of heat or cold, outdoors etc).

11. How many hours would you normally expect to work during the week?

 hrs per week

12. Does the job involve any unsocial hours? If yes, please give full details.

yes no

13. Do you supervise any other staff? If yes, how many.

yes no

 No. of staff

5. MEDICAL DETAILS (TO 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

8. Is your current treatment providing any relief of symptoms? If yes, please give full details

yes no

9. Has there been any improvement in your condition? If yes, please give full details.

yes no

10. Have you discussed returning to your previous job with your GP or Specialist? If yes, please give full details.

yes no

6. 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" value="dd/mm/yyyy"/>	<input type="text" value="dd/mm/yyyy"/>	<input type="text" value="dd/mm/yyyy"/>
<input type="text"/>	<input type="text" value="dd/mm/yyyy"/>	<input type="text" value="dd/mm/yyyy"/>	<input type="text" value="dd/mm/yyyy"/>
<input type="text"/>	<input type="text" value="dd/mm/yyyy"/>	<input type="text" value="dd/mm/yyyy"/>	<input type="text" value="dd/mm/yyyy"/>
<input type="text"/>	<input type="text" value="dd/mm/yyyy"/>	<input type="text" value="dd/mm/yyyy"/>	<input type="text" value="dd/mm/yyyy"/>

7. 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

8. 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.

9. 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. 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

(f) Monthly Earnings

€

(g) Name of employer

(h) Are you still working?

yes no

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?

10. 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	<input type="text"/>		
Policy Number	<input type="text"/>	Yearly amount of benefit	€ <input type="text"/> per year
Start date of policy	<input type="text"/>	Start date of benefit	<input type="text"/>
Deferred period	<input type="text"/>		

11. PREVIOUS CLAIMS

Have you previously had a disability claim with Irish Life or any other company? If yes, please give details.

yes no

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

12. 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?

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

13. 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

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

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

14. ADDITIONAL INFORMATION

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

15. 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.

16. 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

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

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Irish Life Corporate Business