PENSIONS
INVESTMENTS
LIFE INSURANCE

Irish Life

HOSPITAL CASH COVER
CLAIM FORM

000157

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 www.irishlife.ie or you can ask us for a copy.

Dear Claimant

Irish Life's philosophy is to pay all valid claims as promptly as possible. We are available to help and advise you at all stages of the claim process.

In order for us to consider your claim, we require the following:

A fully completed claim form:
- Section A: Must be fully completed by the claimant, signed & dated
- Section B: Must be fully completed by the treating Hospital, signed & dated and stamped.

On receipt of your completed claim form we will start the assessment process
We need relevant 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 relevant personal health information in connection with this claim from GPs, consultants, hospitals or other health professionals. We may use the health information obtained at this claim for any subsequent claims and/or applications to Irish Life.

In certain circumstances we will use the service of Private Investigators. Each 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 the Data Protection Law. Any unauthorised processing, use or disclosure of personal data by Private Investigators is strictly prohibited.

We will keep you informed if any further information is needed.

If you have any questions regarding this claim form or your benefits, you can contact our Protection Claims Team or our Customer Service Team.

Our contact details are as follows:

Protection Claims Team
Irish Life Assurance plc,
Irish Life Centre,
Lower Abbey Street,
Dublin 1.

Email: protectionclaims@irishlife.ie

Tel: 01 704 1855
(Lines open 9am – 5pm Monday to Friday)

Fax: 01 680 3387

Main Customer Service Centre

Phone: 01 704 1010

Email: protection@irishlife.ie

Our lines are open:
8am to 8pm Monday to Thursday
10am to 6pm Friday
9am to 1pm Saturday

In the interest of customer service we will record and monitor calls.

Send your claim form to:
Protection Claims Team
Irish Life Assurance plc
Lower Abbey St
Dublin 1

Please note that the issuing of this claim form is not an admission of liability for a claim.

Giving false information in this claim form could result in your cover being cancelled.

All questions must be answered. Please use BLOCK CAPITALS

Section A – To be completed by the claimant

Claimant Details

Plan number

Mr ◯ Mrs ◯ Ms ◯

If claim is in respect of a child, enter child's name as claimant.

Name of Claimant

Address

Date of Birth d d / m m / y y y y

Adult ◯ Child ◯

1. Name and address of usual Medical Attendant/GP

2. Description of full nature of illness/injury resulting in hospitalisation

If claim is in respect of childbirth, please ignore questions 3, 4, and 5. Please note some restrictions may apply for pregnancy related hospitalisation.

3. If injury please advise

(i) Date of Accident d d / m m / y y y y

(ii) Circumstances of Accident

4. If illness please advise

(i) Date symptoms first appeared d d / m m / y y y y

(ii) Date medical advice first requested d d / m m / y y y y

(iii) Date first attended Doctor(s) completing Section B d d / m m / y y y y

5. Have you consulted a doctor previously for this illness? Yes ◯ No ◯

If Yes, please give full details including dates and doctors/hospitals involved:

6. Have you suffered any illness in the past for which you required medical advice/treatment? Yes ◯ No ◯

Nature of condition

Period of hospital confinement for which claim is being made

Date and Time of Admission d d / m m / y y y y am/pm

Date and Time of Discharge d d / m m / y y y y am/pm

If still confined, please indicate expected duration

Name and Address of Hospital

Payment

In the event that your claim is admitted we can arrange for payment to be made in a number of ways. Please choose how you wish the claim to be paid by ticking the appropriate box:

1. If you wish to receive your payment by cheque please tick here ○
2. If you are currently paying your plan by direct debit and would like payment to be made to this bank account, please tick here ○
3. If you would like your payment to be made to another bank account in your name, please complete the section below and enclose a copy of a recent bank statement dated within the last 6 months. This statement should be for the account you wish payment to be made into and contain your name, address, BIC and IBAN and you should return it with this claim form.

Bank Identifier Code (BIC)

IBAN

Account Name:

Bank Name & Address:

Your BIC and IBAN details can be found on your bank statement. You can also request them directly from your bank.

Important: Please note that the bank account details provided must be your own bank account or an account held jointly by you. Payment cannot be made to a third party or a third party bank account.

I/We wish to have our claim proceeds paid as above

Please sign and date > Your Signature ✗ Date d d / m m / y y y y

Please sign and date > Joint Signature ✗ Date d d / m m / y y y y

Please sign and date > Plan owner's signature ✗ Date d d / m m / y y y y

Declaration

I declare that all answers given by me in this statement are, to the best of my knowledge and belief, true and complete and that I am the person referred to in the particulars given.

I understand and agree that my claim with Irish Life Assurance plc (Irish Life) will be based on all personal and health information Irish Life hold from my applications and all personal and health information received for any claim.

I understand that if I provide false or deliberately inaccurate information on this form my cover may be cancelled.

For children's hospital cash claims, a parent/ policyholder must sign here > Claimant Signature ✗ Date d d / m m / y y y y

Authorisation

I authorise Irish Life to request and receive my personal health information from any GPs, consultants, hospitals or other health professionals who at any time has attended me concerning my physical or mental health and to share my personal health information with any health professional for the purpose of assessing my claim.

Please sign and date > Signature ✗ Date d d / m m / y y y y

Section B - to be completed by the treating Hospital

Claimant's name

Hospital number

1. Describe fully nature of injury/illness

2. On what date were you first consulted on the matter? d d / m m / y y y y

3. How long had the symptoms been present when you were first consulted?

4. To the best of your knowledge has this patient suffered previously from this or a related Illness? Yes ◯ No ◯
   If yes, please give details

5. Period of current hospitalisation
   Date and Time of Admission d d / m m / y y y y am/pm
   Date and Time of Discharge d d / m m / y y y y am/pm
   If still confined, please indicate expected duration

6. Name and Address of Hospital

7. Comments (if any)

Please sign and date

Signed ✗ Date d d / m m / y y y y

Name in Block Capitals

Qualifications

Please ensure this form has been stamped by the treating hospital

Hospital Stamp

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