Irish Life

Hospital Cash Cover

Claim Form – Section A – to be completed by the claimant

All questions must be answered. Please use block capitals

Please return to:

Protection Claims Team
Irish Life
57 Temple Road
Blackrock
Co. Dublin

Email: cli.techclaims@irishlife.ie

Tel: 1850 200 563
(Lines open 9am – 5pm Monday to Friday)

Fax: 01 209 1386

Section A. Claimant Details

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

Note: If claim is in respect of childbirth, please ignore questions 3,4 and 5.

Name of claimant (Mr/Mrs/Ms etc)

Policy No.

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

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

Details	Dates
	dd / mm / yyyy
.	dd / mm / yyyy
.	dd / mm / yyyy

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

Declaration and consent

I hereby declare that all of the 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 consent to Irish Life seeking medical information from any doctor who, at any time, has attended me concerning anything which affects my physical health or mental health or seeking information from any insurance office to which a proposal has been made on my life and I authorise the giving of such information.

Please sign and date

Note: For children's hospital cash claims, a parent / policyholder may sign here.

Signature of claimant ✗

Date d d / m m / y y y y

Section B. Medical Details

Name of claimant (Mr/Mrs/Ms etc)

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. Comments (if any)

Hospital Stamp

Please sign and date

Signed ✗

Date d d / m m / y y y y

Name in Block Capitals

Qualifications

ILA 10755 (NPI 12-13)

Irish Life