Hospital Cash Cover

Claim form -

Section A - to be completed by the claimant

Please return to
Risk Benefits Team
Irish Life Assurance plc
Lower Abbey Street
Dublin 1 Ireland
Telephone 01 704 2000
Fax 01 704 1921

Irish Life

All questions must be answered. Please use block capitals

Claimants details

Name of claimant Mr/Mrs/Ms Policy no

Address

Date of birth / /

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 / / (ii) Circumstances of Accident

4. If illness please advise (i) Date symptoms first appeared / /

   (ii) Date medical advice first requested / /

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

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

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. Also note restrictions for pregnancy related hospitalisations summarised opposite.

Period of hospital confinement for which claim is being made

Date and Time of Admission / / am /pm

Date and Time of Discharge / / am /pm

If still confined, please indicate expected duration

Name and Address of Hospital

Declaration and consent

I hereby 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 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.

Signature of claimant Date / /

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

Hospital Cash Cover

Claim form - Section B

Claimants details

Claimant's name Mr/Mrs/Ms

1. Describe fully nature of injury/illness

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

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 / / am /pm

Date and Time of Discharge / / am /pm

If still confined, please indicate expected duration

7. Comments (if any)

Signed

Date / /

Hospital Stamp

Name in Block Capitals

Qualifications

ILA 0390 Rev 2000/02