Irish Life

SPECIFIED ILLNESS COVER

A guide to making a claim

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1 INTRODUCTION

INTRODUCTION

We have written this booklet to help you understand what is involved when you claim under your specified illness cover.

At Irish Life, we understand the difficult time that you face after being told you have a serious illness. We hope this booklet helps to explain our claims process.

What is specified illness cover?

Specified illness cover is a benefit which pays a one-off lump sum if you suffer one of the specific illnesses covered under your plan. Typically, the major conditions covered include certain types of malignant cancer, diagnosed heart attack, stroke with permanent symptoms and multiple sclerosis. Each illness is defined in your plan conditions.

2 THE CLAIM PROCESS

THE CLAIM PROCESS

How do I make a claim?

If you want to make a claim under your specified illness cover, you should contact our customer service centre on 01 704 1010. When you call, you should give your plan number and some general details (such as your name and phone number). You can also tell us about a specified illness cover claim on our website - visit www.irishlife.ie.

One of our specified illness claims assessors will then phone you to explain the claims process. They will answer any questions you may have about how you claim.

If the condition you are claiming for is covered under the plan, the claims assessor will then send you a claim form within five working days of receiving your request.

The claim form is a way of giving us the details of your condition, the names of the doctors and medical specialists you have seen, details of your medical history and any other information you think will be useful to help us process your claim. This form includes a section for you to sign that will give us permission to contact your doctor and any medical specialists you have seen for reports on your medical history, and to contact any other Insurance company you may have life or specified illness cover with.

For claims relating to malignant cancer, diagnosed heart conditions and stroke with permanent symptoms, the claim form has two parts. One part is for you to complete and one part is for you to bring to your GP or specialist to complete.

- Please include a copy of valid photographic identification (e.g. Passport or driving license of the person claiming) with your claim form.

- You also need to send us verification of your address if this had changed in the last 12 months (e.g. utility bill or bank statement). If there are two lives on your plan, we will require identification for both of you.

As part of changes to Anti Money Laundering legislation, we require identification from all claimants when a claim is made. This requirement is to protect all financial services customers from any identity theft or fraud.

Note: We do not require identification where a plan is assigned and where the full proceeds of the claim is payable to a bank or financial institution.

What happens when I return my claim form?

When you send us a filled in claim form, one of our specified illness claims assessors will contact you again to tell you what other information we need in order to assess your claim. We will write to your doctors if we need to ask them for medical information about you.

Who do you ask for my medical information and why?

We will usually ask the following people for your medical information.

- Your GP – to confirm the condition you have has been diagnosed and to get details of your medical history
- Your medical consultant/specialist (if you have one) – to confirm the diagnosis of your condition
- Any previous GP you have been to – to get details of your medical history

Why do you need details of my medical history?

As your contract with us is based on the medical questions you answered on your application form when you applied for your plan, we will need details of your medical history to confirm that all the information you gave us on your application form was correct.

We assess all claims to make sure they are valid. This protects our customers against the effects of increased claim costs, which could lead to higher premiums for you. We want to avoid this.

We pay most specified illness claims that we receive, but sometimes we have to turn down a small number of claims.

Here are some examples of why we may not pay a claim.

- If the illness being claimed for is not covered under the plan. For example, we would refuse a claim for a stomach ulcer because it is not one of the specific illnesses listed in our plan.
- If you do not meet our definition of an illness under the plan. For example, we would refuse a claim for removing a skin lump or growth which was not a malignant cancer.
- If you did not give us full and proper details on your original application for cover. For example, if you:
  - had a history of high blood pressure and high cholesterol and you take medication to treat these, but you did not tell us about this on your original application form; or
  - told us on your application form that you were a non-smoker, but your medical evidence shows that you were a tobacco smoker at the time you took out the plan.

Appeals

If you wish to appeal a decision made on your claim you should write to us outlining the exact reasons for your appeal and enclose any additional information you feel we should take into account. Your claim file will be reviewed in full by another claims assessor and an appeal decision will be issued to you.

We may refuse to pay a claim even if there is no direct medical connection between the illness you are claiming for and the medical condition you have not told us about on the application form. To do this we must be able to show that the facts you did not tell us about at the time you applied, would have affected our original decision to provide cover.

How long will it take to assess my claim?

Usually, a specified illness cover claim takes 8 to 10 weeks for us to complete. Some claims will take longer than this, however, 30% of specified illness cover claims are paid in 4 weeks or less.

Because we need detailed medical information to assess your claim, we rely on your doctors and the medical specialists you have seen to give us the information we need. We remind doctors regularly about the medical information we have asked for, but it can still take them time to give us all the information we need.

Sometimes, if the information we are given is not clear or we need some extra medical information, we will write back to your doctors for this information.

We try our best to assess claims as quickly as possible. We will keep you up to date on how your claim is progressing.

Who will assess my claim?

Your claim will be assessed by qualified and experienced claims assessors, including qualified nurses and our chief medical officers who are consultant doctors.

We will keep any medical information that we ask for confidential. All of our claims assessors must keep to a code of practice when they work with medical evidence. Any medical information we receive will only be seen by people who are authorised to do so.

3 CLAIM PAYMENT

If you pay my claim, who will you pay the money to?

If your plan is held in just your name, we will send you a cheque in your name.

If your plan is a joint or dual-life plan (meaning that two lives are covered under the plan), we will make the cheque out to both people covered.

If you have used your plan as security for a bank loan, we will make the cheque out to the bank. (This does not apply to children's specified illness cover claims.)

If the plan is owned by a business, we will make the cheque out to the business name.

The benefits you receive will be tax-free.

Do you pay interest on specified illness cover claims?

We pay a small amount of interest on most specified illness cover claims. When we are told about a specified illness cover claim, we invest the amount of benefit due in a cash fund. The interest rate is worked out based on the growth of this fund.

Tax is taken from the interest that we earn on the money in the cash fund. This is called deposit interest retention tax (DIRT). This is a tax that, by law, we must take from the interest and pass it to the Revenue Commissioners. DIRT is currently charged at a rate of 30%.

If you have any questions about the DIRT we pay to the Revenue Commissioners, please visit www.revenue.ie.

What happens to my plan when you pay my claim?

What happens to your plan after you make a claim depends on the type of specified illness cover you have, whether you have any life cover and whether your plan is a single-life or dual-life plan. When we pay your claim, we will write to you confirming whether you are still covered by your plan and for what benefits.

4 CHILDREN'S COVER

Are my children covered under specified illness cover?

Your children will be covered, free of charge, if they are between the ages of one and 21. They are generally covered for the same illnesses listed in your plan conditions. Children are also covered for bacterial meningitis. Please see your plan conditions for full details.

Because we do not ask for any medical evidence for your children when you take out your plan, certain restrictions apply to your children's cover. Children are not covered for illnesses they had before they were one year old or before the start date of your plan. Please see your plan conditions for full details of children's cover and the amount we will pay you if you claim.

If you want to make a child claim please contact us on 01 704 1010.

5 CONTACT DETAILS

Who can I contact if I have a question about my claim?

If you have a question about your claim, you can contact one of our specified illness cover claims assessor in one of the following ways.

Phone: 01 704 1855

Fax: 01 680 3387

E-mail: protectionclaims@irishlife.ie

Post: Protection Claims Department,
Irish Life,
Lower Abbey Street,
Dublin 1.

Our office hours are from 9am to 5pm.

If you need to contact us outside these hours or speak to a member of our customer service department, you can e-mail protection@irishlife.ie or call 01 704 1010.

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.

6 OTHER USEFUL INFORMATION

Free counselling service

We want to help you during this difficult period after the diagnosis of a serious illness. That is why we will offer you up to three free counseling sessions with the Clanwilliam Institute while you are making a specified illness cover claim. The Clanwilliam Institute is an independent, Irish company and registered charity, who were set up in 1982. The institute provides counselling and psychotherapy services for individuals, couples and families. Over the years, Clanwilliam has helped many people through difficult times, including stress, major illness, relationship difficulties, or bereavement.

The Clanwilliam Institute has offices in Dublin, Portlaoise, Kilkenny, Wexford, Dundalk, Wicklow, Roscommon, Galway, Sligo, Nenagh, Roscrea, Limerick, Cork and Dungarvan.

If you would like to use this service, please contact one of our specified illness claims assessors. We will then contact the Clanwilliam Institute and let them know that you would like to take up this offer. You can then contact the Clanwilliam Institute to arrange an appointment on 01 676 1363 or 01 676 2881.

Any counselling sessions you have with the Clanwilliam Institute will be strictly confidential. They will not tell us anything that you tell them in your counselling sessions.

Nurse Assist 24/7

If you have a serious medical condition, you will probably have many questions about your illness, the medicines you may need to take or tests you may need to have.

Under your specified illness cover, we offer a service where you can phone and speak to a team of trained nurses who can help with any medical questions you have.

These nurses do not work for us and anything you tell them will be kept confidential. The team of nurses will not have access to any of your Irish Life plan or claim details. They will not tell us or anybody else anything that you tell them.

Nurse Assist 24/7 is a confidential helpline that you can call 24 hours a day, 365 days a year and there is no charge for the service. You will need to have your Irish Life plan number handy when you call. The lo-call phone number is 1850 22 88 33.

What if I have a complaint or do not agree with a decision you have made?

If you have any reason to complain to us, you can contact us in any of the ways given in section 12 (see page 15). We will do our best to sort out your complaint fairly and quickly through our internal complaints procedure.

If you would like a copy of our customer complaints charter, please let us know and we will send one to you. A copy of our charter can be viewed on our website – visit www.irishlife.ie.

If you are unhappy with the outcome of your complaint, you can have your complaint reviewed by the Financial Services Ombudsman.

The Financial Services Ombudsman is an independent organisation who sort out complaints made about financial organisations. Their contact details are as follows.

Financial Services Ombudsman
3rd floor, Lincoln House
Lincoln Place
Dublin 2

Lo-call: 1890 88 20 90

Phone: 01 6620899

Fax: 01 6620890

E-mail: enquiries@financialombudsman.ie

Website: www.financialombudsman.ie

From sustainably managed forests -
For more info: www.pefc.org

Contact us

Phone: 01 704 1010

8am to 8pm Monday to Thursday
10am to 6pm on Fridays
9am to 1pm on Saturdays

Fax: 01 704 1900

e-mail: protection@irishlife.ie

Website: www.irishlife.ie

Write to: Irish Life Assurance plc, Lower Abbey Street, Dublin 1.

In the interest of customer service we will record and monitor calls.
Irish Life Assurance plc, Registered in Ireland number 152576, Vat number 9F55923G.

Irish Life Assurance plc is regulated by the Central Bank of Ireland.

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