



## Accident Cover Claim Form – Fractures & Dislocations

This claim form should only be completed if you are claiming for one of the Qualifying Injuries – please refer to the back page for the list of injuries covered

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

- **Section A:** Must be fully completed by you
- **Section B:** Must be fully completed by your current medical attendant
- All sections of the claim form must be signed & dated
- Photo and address identification for all people named on the plan (eg copy of passport/drivers licence)

Please note we will not be able to assess your claim without all of the above.

This claim form must be returned within two weeks of us posting it to you.

If there is a delay in returning this claim form we may not be in a position to consider your claim.

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

### Protection Claims Team

**Phone:** (01) 704 1855  
Monday – Friday 9am – 5pm

**Fax:** (01) 680 3387

**Email:** [protectionclaims@irishlife.ie](mailto:protectionclaims@irishlife.ie)

### Customer Service Team

**Phone:** (01) 704 1010  
Monday – Thursday 8am – 8pm  
Friday 8am – 6pm  
Saturday 9am – 1pm

**Fax:** (01) 704 1900

**Email:** [protection@irishlife.ie](mailto:protection@irishlife.ie)

### Send your claim form to:

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

## Section A – To be completed by the claimant

### Claimant details:

Name of claimant:	<input type="text"/>
Policy number:	<input type="text"/>
Address:	<input type="text"/> <input type="text"/>
Date of birth:	<input type="text" value="dd / mm / yyyy"/>
Occupation:	<input type="text"/>
Phone number:	<input type="text"/>
Name of GP:	<input type="text"/>
Address of GP:	<input type="text"/> <input type="text"/>

### Accident details:

1. Date of accident	<input type="text" value="dd / mm / yyyy"/>	Time of accident	<input type="text"/>
2. Place of accident	<input type="text"/> <input type="text"/>		
3. What were the circumstances of the accident, i.e. what were you doing at the time the injury was sustained?	<input type="text"/> <input type="text"/>		
4. How was your injury sustained?	<input type="text"/> <input type="text"/> <input type="text"/>		
5. What is the location of the fracture or dislocation?	<input type="text"/> <input type="text"/> <input type="text"/>		
6. Date of any period of hospitalisation (From – To, Name of Hospital)	<input type="text"/> <input type="text"/>		
7. What treatment did you receive?	<input type="text"/> <input type="text"/> <input type="text"/>		
8. If a dislocation, have you previously dislocated this joint? If yes, please give the date.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: <input type="text" value="dd / mm / yyyy"/>

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 or mental health and I authorise the giving of such information.

Signed:	<input type="text" value="X"/>	Date:	<input type="text" value="dd / mm / yyyy"/>
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## Section B – To be completed by your specialist

### Claimant details:

Name:

Occupation:

How long have you been the claimant's medical attendant?

### Injury details:

1. Date of accident
2. Place of accident
3. Circumstances of the accident
4. Exact nature of injury sustained
5. Please provide the exact details of any bone fracture or joint dislocation?
6. Please confirm the date and results of all x-rays?
7. What treatment did the claimant receive? Please include details of medication, physical aids, physiotherapy and surgery carried out.
8. Is any further treatment planned? If so, please provide full details.
9. Has the claimant previously suffered from a similar injury? If so, please provide full details.

I certify that I have personally examined the claimant and that all foregoing statements are correct.

Signed:

Qualifications:

Date:

## Qualifying Injuries

The following is the list of qualifying injuries covered under Accident Cover:

- Fracture of the upper leg
- Fracture of the lower leg or ankle
- Fracture of the arm
- Fracture of the wrist
- Fracture of the vertebrae, shoulder blade or sternum
- Fracture of the jaw or cheekbone
- Fracture of the foot
- Fracture of the ribs or collarbone
- Open fracture of the skull
- Closed fracture of the skull
- Dislocation of the hip
- Dislocation of the ankle
- Dislocation of the elbow
- Dislocation of the shoulder

### Please note:

- Please refer to your plan terms and conditions for full details on the above fractures.
- Fractures to fingers, toes and nose are not covered.
- If you suffer multiple fractures as a result of a one accident, benefit will be paid once in respect of the qualifying injury which results in the highest claim payment.

