Irish Life

Accident Cover Claim Form

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
- **Section C:**
  - If you are an employee part 1 must be fully completed by your employer
  - If you are self employed part 2 must be fully completed by you
  - If you are unemployed part 3 must be fully completed by you
- **All sections of the claim form must be signed & dated**
- **Photo and address indentification 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.

When we receive your claim form we will start the assessment process. This process typically involves the following tasks:

1. Verifying the injury sustained and the circumstances of your accident
   - we may request reports from doctors and specialists you have attended
   - we may request an independent medical examination
   - we may arrange for someone to visit you at home
2. Determining how long you will be unable to carry out your job
   - this assessment will be made by our Chief Medical Officer or other relevant health professionals
3. Calculating your weekly benefit based on your earnings
   - The maximum amount you can receive is 40% of your weekly earnings
   - Proof of your earnings is required (refer to section C)

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

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

Send your claim form to:

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

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

Section A – To be completed by the claimant

Claimant details:

Name of claimant:

Policy number:

Address:

Date of birth: dd / mm / yyyy

Occupation:

Phone number:

Gross earnings in the year before the accident: €

Amount of weekly sick pay: €

Name of GP:

Address of GP

Accident details:

1. Date of accident dd / mm / yyyy Time of accident

2. Place of accident

3. What were the circumstances of the accident, i.e. what were you doing at the time the injury was sustained?

4. How was your injury sustained?

5. What was the exact nature of the injuries sustained?

6. Date of any period of hospitalisation (From – To, Name of Hospital)

7. What investigations did you undergo?

8. What treatment did you initially receive?

9. What date did you stop working? dd / mm / yyyy

10. How are you physically limited in your daily life?

Following accident	Currently

11. Specifically, what part of your job are you physically unable to do as a result of your injury?

12. How have your symptoms improved since the date of your accident? Please provide details of the progress of your recovery.

13. What treatment are you currently taking?

14. What advice has your doctor given to you regarding returning to work?

15. When do you anticipate that you will be able to return to work? Please give details of the factors that are influencing the date you will return to work.

dd / mm / yyyy

16. Since your disability began, have you undertaken any duties of your normal occupation?

17. Since your disability began, have you undertaken any other work (paid or unpaid)? Yes ☐ No ☐

If Yes, please give details

18. Are you insured against accident, sickness or disability with any other insurance company? (e.g. income protection insurance) If yes, please provide full details

Name of insurance company

Benefit amounts €

Policy number (if available)

19. Have you ever suffered any illness in the past for which you have required medical advice or treatment? Yes ☐ No ☐

If Yes, please give details

20. Please provide the names and addresses of all doctors and specialists you have attended in relation to your injury

21. Please provide dates for all appointments you have attended and details of any upcoming appointments

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 or mental health and I authorise the giving of such information. I consent to Irish Life seeking information in connection with this claim form from any source which Irish Life deem necessary and I authorise the given of such information. I fully understand that I must notify Irish Life immediately if I resume my normal occupation either on a full time or part time basis, or if I take up alternative work whether paid or not, as failure to do so will result in my claim being rejected or payments being terminated and cover ceasing.

Signed: ✘ Date: dd / mm / yyyy

Section B – To be completed by your medical attendant

Claimant details:

Name:

Occupation:

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

Accident details:

1. Date of accident dd / mm / yyyy

2. Date of first consultation dd / mm / yyyy

3. Circumstances of the accident

4. Exact nature of injuries sustained

5. Please provide details of all investigations carried out:

	Test	Result	Date
1			dd / mm / yyyy
2			dd / mm / yyyy
3			dd / mm / yyyy
4			dd / mm / yyyy

Please provide copies of all results if available.

6. On what date did incapacity commence? dd / mm / yyyy

7. Initially, what were the physical symptoms preventing the claimant from working?

8. What treatment was initially provided? Please include details of medication, physical aids, physiotherapy and surgery carried out.

9. Is the claimant fit for work now? Yes ☐ No ☐ If Yes, from what date? dd / mm / yyyy

10. Was the total duration of incapacity reasonable for this injury? Please give reasons for your answer.

Ongoing incapacity details:

11. Currently, what is causing the claimant's incapacity?

12. Currently, what aspects of the claimant's occupation are they unable to carry out as a result of their injury?

13. Please provide details of any improvements or deterioration since the date incapacity commenced.

14. Has the claimant consulted a specialist with their injury, if so, please give details:

	Name	Date	Outcome
1		dd / mm / yyyy	
2		dd / mm / yyyy	
3		dd / mm / yyyy	
4		dd / mm / yyyy	

Please provide copies of all reports and results if available.

15. Please provide exact details of current treatment. Please include details of medication, physical aids, and physiotherapy.

16. Is this treatment providing relief of symptoms? Yes ☐ No ☐

17. If the treatment is not providing relief, can you outline why?

18. Is a change of treatment being considered? Yes ☐ No ☐

If Yes, when do you expect this to commence? dd / mm / yyyy

What outcome would you anticipate from this new treatment?

19. When do you expect the claimant to be fit for work? dd / mm / yyyy

20. Is the duration of incapacity reasonable for this injury? Yes ☐ No ☐

Please give reasons for your answer

21. Is the claimant still attending you? Yes ☐ No ☐

22. Please give the date you last saw the claimant regarding the injury. dd / mm / yyyy

23. Is a further review planned? Yes ☐ No ☐

24. Has the claimant previously suffered from similar symptoms or injury? Yes ☐ No ☐

If yes, please provide details

25. Are you aware of any other medical history, medication, investigations or specialist treatment the claimant had prior to attending you?

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

Signed: ✘ Date: dd / mm / yyyy

Qualifications:

Section C – Employment Details

1. If employed – Please have your employer complete the following:

Name of employer | Nature of business

Name of employee | Date employment commenced dd / mm / yyyy

Date last worked dd / mm / yyyy

Reason for stopping work on this date

What is their precise occupation? | Is the employee due to return to work? Yes ☐ No ☐

Please describe the main duties of their occupation

Please enclose a copy of the employees most recent P60.

Signed: ✘ | Stamped:

Company Number: | VAT Number:

2. If self employed – please complete the following:

Please describe the exact nature of your business

Please describe the main duties of your occupation

Please provide details on how your incapacity from your work impact on your business (e.g. loss of profit, employing extra staff)

Please enclose copies of accounts, tax computations and income tax assessment for the last full tax year.

Signed: ✘ | Stamped:

Company Number: | VAT Number:

We cannot consider payment without evidence of earnings as outlined above.

3. If unemployed – please complete the following:

What date did you become unemployed? dd / mm / yyyy

What was your occupation prior to becoming unemployed?

Please describe the main duties of your previous occupation

Irish Life