Life Options

Accident Cover Claim Form

Return to:

Risk Benefits Team

Lower Abbey Street
Dublin 1 Ireland
Telephone 01 704 1857
Fax 01 704 1906

Irish Life

Please read each question carefully before answering and use capital letters throughout.

If you are making a claim for an **up front payment in** respect of one of the listed fractures or dislocations, please:

1. Complete Section A answering all questions fully and sign the Declaration.
2. Arrange for the doctor who treated the claimant in hospital or otherwise to complete, stamp and sign Section C.

If you are making a claim for a **weekly benefit** because you are unable to work as a result of an injury received in an accident, please

1. Complete Sections A and B answering all questions fully and sign both Declarations.
2. Arrange for the doctor who is treating the claimant to complete, stamp and sign Section D.
3. If the claimant is self-employed, and the weekly benefit exceeds €200 enclose evidence of earnings in the form of copies of accounts, tax computations and income tax assessment for the last full tax year.
4. If the claimant is an employed person, enclose a letter from their employer confirming yearly salary and the fact that they are absent from work (with relevant dates). If the weekly benefit exceeds €200, please also provide evidence of earnings in the form of a copy of the claimant's P60 for the last full tax year.

Submit the completed form to Risk Benefits Team, Irish Life Assurance plc, Irish Life Centre, Lower Abbey Street, Dublin 1.

It is important that you read the notes overleaf and refer to your policy documentation to establish what, if any, cover applies to you. Sections C and D must be completed at the claimant's expense. We will endeavour to pay all valid claims as soon as possible. In some instances we may have to seek clarification from an attending doctor or visit the claimant.

Please note that the issuing of this form is in no way an admission of liability.

Giving false information in this claim form could result in your cover being cancelled.

May 2002

Brief Summary of Accident Cover – refer to your policy document for full details

Note:
Accident cover ends at age 60.

Weekly Benefit

- Benefit is payable if the claimant is unable to do their normal work as a direct result of an injury received in an accident.
- No benefit is payable for the first two weeks of any period of incapacity.
- Benefit ends when the claimant returns to work or when Irish Life decides he or she is fit enough to return to work, whichever is earliest.
- The maximum benefit we will pay is the lower of the insured weekly benefit and 40% of actual gross earnings in the year before incapacity starts.
- Benefit will be paid for a maximum period of 52 weeks over the lifetime of your policy. Any benefits paid under up front payments will count towards this 52 week maximum.

Up Front Payments

If any of the following fractures or dislocations occur , an up front payment will be made irrespective of whether the claimant returns to work. The following number of weeks benefit will be paid in such circumstances.

Fracture of femur or hip.	12 weeks
Fracture of the tibia, fibula, patella or tarsus (ankle bone).	10 weeks
Fracture of the humerus or upper two thirds of the radius or ulna.	10 weeks
Fracture of any of the carpal bones or lower one third of the radius or ulna.	6 weeks
Fracture of any of the vertebrae, scapula or sternum.	4 weeks
Fracture of the mandible, maxilla or cheek bone.	4 weeks
Fracture of the oscalcis, talus, the tarsal bones or metatarsals (phalanges are not included).	6 weeks
Fracture of any of the ribs or clavicle or closed fracture of the skull.	4 weeks
Open fracture of the skull.	12 weeks
Dislocation of the hip, ankle, elbow or shoulder.	4 weeks

No fractures or dislocations other than those listed below are covered for Up Front Payments. In particular, fractures to smaller bones such as fingers, toes and nasal bones are not covered. We will only make one up front payment in any two year period for a shoulder dislocation.

Some of the exclusions and conditions that apply to Accident Cover are listed below– refer to your policy terms and conditions for full details.

Accident Cover is not payable

- If the injury is self inflicted or occurs ;
  (a) as a result of the taking of alcohol or drugs or ,
  (b) as a result of war or participation in a criminal act or,
  (c) outside the accepted residences or,
  (d) as a result of an accident whilst driving a motor cycle.

- If the injury occurs as a result of participation in abseiling, bobsleighing, boxing, hang-gliding, horse racing, motor car and motor cycle racing or sports, mountaineering, parachuting, pot-holing or caving, power boat racing, rock climbing, scuba diving or flying other than as a fare paying passenger on a regular public airline.

- If the claim for weekly benefit is caused directly or indirectly by a mental or functional nervous disorder.

Accident Cover: Weekly Benefit

Claim form: SECTION D, Medical Certificate

To be completed by the doctor who is attending the claiment.

Note:
Completion of this certificate is required in order to assess an Accident Cover claim. A claim is payable in the event of your patient being medically unfit to follow their normal occupation as a result of an injury sustained in an accident. Full completion of this certificate will result in prompt processing of your patient's claim.

1. Claimants Details

Claimant's Name _____ Date of Birth / /

Occupation _____

1. Relationship to Claimant

(a) Are you the claimant's usual medical attendant? ☐ yes ☐ no
If yes, how long?

(b) When did you first see the claimant with this incapacity?

(c) Are you still attending the claimant ☐ yes ☐ no If so, date last seen / /

(d) What is the anticipated frequency of future consultations related to this injury with:

Yourself

Any other treating doctor

2. Accident Details

(a) (i) Date of Accident / / (ii) Place of Accident

(b) Circumstances, nature and cause of the accident, if RTA state type of vehicle involved

(c) Exact nature of injuries sustained

(d) Has the claimant previously suffered from similar symptoms or injury. If yes, please provide full details ☐ yes ☐ no

3. Nature of Incapacity

(a) Date disability commenced / /

(b) Exact nature of disability?

(c) Exact nature of symptoms which are preventing the claimant from working?

(d) Results of any investigations carried out?

(e) Is the patient's condition:

(a) improving ☐ yes ☐ no

(b) deteriorating ☐ yes ☐ no

(c) static ☐ yes ☐ no

Accident Cover: Fractures and Dislocations

Claim form: SECTION C

To be completed by the doctor who attended the claimant for the injury:

1. Claimants Details

(a) Claimants' Name

(b) Hospital Reference No:

2. Accident Details

(a) Date of Accident / /

(b) Place of Accident

(c) Circumstances, nature and cause of the accident, if RTA state type of vehicle involved

(d) Exact nature of injuries sustained

(e) Give exact nature of any bone fracture or joint dislocation, if a skull fracture, was it compound?

(f) Date and results of all x-rays

(g) Treatment

(h) Has claimant previously suffered from a similar injury ☐ yes ☐ no
If Yes, details

Signed

Qualifications

Date / /

Hospital Stamp
or Doctor's Stamp

Note:
Completion of this form is required in order to assess a fractures and dislocations claim. Full completion of this form will result in prompt assessment of your patients claim.

Accident Cover

Claim form: SECTION A

To be completed by the claimant:

1. Claimants details

Name of claimant _____ Policy No _____

Address _____ Date of Birth / /

_____

Occupation _____ Home Tel. No _____

Revenue & Social Ins No: _____

Gross earnings in the year before the accident €_____

Name and address of usual Medical Attendant _____

_____

_____

Note:
If you are making a claim for an up front payment please have Section C completed in addition to Section A.

Note:
If you are making a claim for weekly benefit, please have Section D completed in addition to Sections A and B.

2. Accident details

(a) Date of accident / / Time of accident _____ a.m. / p.m.

(b) Place of accident _____

(c) Circumstances, nature and cause of accident i.e. what were you doing at the time the injury was sustained

X _____

_____

_____

(d) Exact nature of injuries sustained _____

_____

_____

(e) Dates of any period of hospitalisation from / / to / /

in _____ (name of hospital)

(f) Location of fracture or dislocation or injury _____

_____

(g) Treatment received _____

_____

_____

(h) If a dislocation, have you previously had a dislocation of this joint ☐ yes ☐ no

If, Yes date / /

3. Declaration and Consent

I declare that to the best of my knowledge and belief, the information given in this claim form is 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 anytime, has attended me concerning anything which affects my physical or mental health and I authorise the giving of such information.

Signature of claimant _____ Date / /

Claim form: SECTION B

To be completed by the claimant in addition to Section A where a weekly benefit is being claimed

Occupation Details

1. Are you self employed or an employed person?

2. What was your precise occupation(s) immediately prior to disablement as a result of your accident?

3. Please describe your normal duties in detail

4. Are there any aspects of your pre-disability occupation which you believe could exacerbate your current disability? ☐ yes ☐ no

   If yes, please give full details

5. Have you made any plans to resume your normal occupation? ☐ yes ☐ no
   If yes, please advise when you expect to be able to do so

6. Are you currently in receipt of any sick pay? ☐ yes ☐ no

   If yes, how much? € When is it due to cease? / /

Medical Details

7. Please describe in detail the condition or disability you are currently suffering from

8. What was the nature of the initial symptoms and when did they first occur?

9. Please state the exact date on which you stopped working / /

10. How often are you limited or restricted by your disability and on average how long does this last?

11. What treatment are you currently taking? Please include dosage

12. Are you using any physical aids e.g. walking sticks or collars? ☐ yes ☐ no
    If yes, please give full details

13. Have you discussed returning to your previous job with your doctor? ☐ yes ☐ no
    If yes, please give full details

Note:
Please provide as much information as possible as this will facilitate prompt assessment of your claim.

Medical Attendant Details

14. Please list the full names and addresses of all doctors/specialists who are treating you. Please also advise the date last attended and the dates of any future appointments.

Name and address of doctor/consultant Date last attended Date of next appointment

Other Information

15. (a) Have you previously suffered from an injury similar to this one? ☐ yes ☐ no
If yes, please provide full details with dates

(b) Have you previously suffered from any injury, illness or sickness causing you to be unable to work for more than four weeks? ☐ yes ☐ no
If yes, please give particulars with approximate dates and periods of incapacity

16. Since your disability began, have you

(a) undertaken ANY of the duties of your ordinary occupation? ☐ yes ☐ no

(b) undertaken ANY other work (whether paid or not)? ☐ yes ☐ no
If you have answered YES to either of the above, please provide full details

17. If you have been unable to undertake any work whatsoever, please advise when you anticipate that you may be able to do so?

18. Are you insured against accident, sickness or disability with any other insurance company, If yes, please provide full details ☐ yes ☐ no

19. Please provide any additional information you feel would assist us in assessing your claim.

Note:
It is important that you inform Irish Life of any earnings you are in receipt of or work you are undertaking. Failure to do so could result in your claim being rejected and all cover ending.

Declaration and Consent

I declare that to the best of my knowledge and belief, the information given in this claim form is true and complete and that I am the person referred to in the particulars given. I also 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. 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 giving of such information. I consent to Irish Life seeking information from any doctor who at any time has attended me concerning anything which affects my physical or mental health or seeking information from any insurance office to which a claim has been made by me and I authorise the giving of such information.

Signature of claimant Date / /

4. Treatment

(a) Please provide exact details of treatment

(b) Is the treatment providing any relief of symptoms? ☐ yes ☐ no
If yes, please give full details

5. Extent of Disability

(a) Is the claimant in your opinion currently able to carry out all of the duties of his/her normal occupation?

☐ yes ☐ no

If yes, please confirm the exact date on which he/she was fit to do so? / /

If no, please confirm the following: Is the disability in your opinion

☐ short term (1 – 2 mths) ☐ medium term (3 – 6 mths) ☐ long term (6 mths +)

(b) What aspects of the claimant's normal occupation is he/she currently able to perform?

(c) What aspects is the claimant currently unable to perform?

(d) Is the claimant in your opinion currently fit to resume his/her normal occupation on a part time basis?

☐ yes ☐ no
If yes, please outline below the nature of work and the number of hours per week that could be performed.

6. Other Doctors or Specialists

Please give the name and address of any other doctor or specialist attended including the date last attended and the dates of any future appointments

Name and address of Doctor/Consultant	Date last attended	Date of next appointment

Additional Information

Please state any additional information which may be of assistance in the ongoing management of this claim

Signature

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

Doctor name (please print)

Qualifications

Address

Hospital Stamp
or Doctor's Stamp

Signature

Date / /