

Serious Illness Claim Form

Policy Number:		Life Insured:	
Telephone Number:		Address:	
Occupation:		Date of Birth:	

Section 1

1. You can only submit a claim for Serious Illness Benefit if you have suffered from one of the *Critical Events* listed in your Policy Document. Please specify which *Critical Event* you are suffering from.

2. On what date did you first consult a medical practitioner in connection with your illness/disability?

3. Was this your usual medical attendant?

YES NO

4. If not, please confirm the name and address of the doctor attended.

5. What symptoms preceded diagnosis of the illness and on what date did they commence?

6. Have you undergone any tests or investigations to confirm the diagnosis?

YES NO

If yes, please supply details as to the nature, date and result of the tests/investigations.

7. What treatment have you received, or are you currently receiving, in connection with your illness/disability.

8. Have you previously suffered from, or received treatment for, a similar illness?

YES NO

If yes, please provide details of the dates of previous occurrences or treatment.

9. Has any blood relative suffered from a similar, or related, illness/disability?

YES NO

If yes, please state the relationship, nature of illness/disability suffered and the date this illness/disability was first diagnosed.

10. Do you smoke cigarettes?

YES NO

If yes, what is your daily consumption?

If yes, what date did you commence smoking?

If you are not currently a smoker, can you advise if you have ever smoked in the past?

If yes, please indicate what dates you smoked in the past and the duration of time you were a smoker?

11. Please provide full details of any other insurance policies under which you may receive payment for this condition, stating the name of the insurer, policy number and amount of benefit.

12. What is the name and address of your usual medical attendant?

13. Please confirm the Name and Address of the Specialist being attended in relation to your illness.

14. Have you consulted any other doctor, specialist or hospital as an in-patient or as an outpatient?
YES /NO

If yes please supply their names and addresses along with the date of first attendance and most recent attendance

15. Please give the names and addresses of any other doctors you have attended in the last five years for any reason.

I declare that the above statements are true and complete and I am the person referred to in the particulars given.

I understand that if any of these statements are knowingly or recklessly untrue my policy will be cancelled immediately and no benefit will be payable.

I consent to Zurich Life Assurance plc seeking information from any doctor who has attended me, or subsequently attends me, or from any hospital in which I received treatment, or subsequently receive treatment, and I authorise the giving of such information.

I also authorise the release to Zurich Life Assurance plc. of any information which the Company considers relevant to enable my claim to be dealt with.

Signed

Date
