

Hospital Cash Benefit

If you have any questions while filling out this Claim Form, or if you're unsure about any aspect of your policy terms and conditions, please contact Zurich Life. We're here to help and happy to support you every step of the way. You can get in touch by calling Customer Services at **01 799 2711** or email us on **customerservices@zurich.com**

Life Insured

Policy Number

Email Address

1. Please state the exact nature of the illness/disease/injury for which you are/were hospitalised.

Please confirm the date that you first attended a doctor for this condition.

2. What were your symptoms?

What date did they first start?

3. Please give details of all surgery/treatment/procedures undertaken.

4. Have you previously suffered from this or any related condition? Yes No

If yes, please give details.

Continued overleaf

5. What is the name and address of your usual doctor?

Name:

Address:

6. Please specify the exact time and date of admission and discharge.

Admission: Time

Date

Discharge: Time

Date

7. Please give the name and address of the hospital and the name of the doctor(s) attended there.

Hospital:

Doctor(s)
attended:

Declaration

I declare that the above statements are true and complete and that I am the person referred to in the particulars given. In order to process this claim, I acknowledge that it may be necessary for Zurich Life Assurance plc ('Zurich Life') to seek information from any doctor who has attended me or subsequently attends me, or any hospital in which I have received or subsequently receive treatment, and I authorise the giving of such information. I also authorise the release, to Zurich Life, of any other information, which Zurich Life considers relevant to enable my claim to be dealt with.

Name:
(Please Print)

Signature:

X

Date:



Please sign and date.

Continued overleaf

Certificate of Hospitalisation

Life Insured

Policy Number

Email Address

1. Please state the exact diagnosis of the condition for which the patient attended hospital.

2. Was there any underlying illness? If so, please give details including any previous history.

3. Please detail all surgery/treatment/procedures undertaken.

4. What was the date of the first consultation for this condition?

5. Please advise the name and address of the referring doctor.

Name:

Address:

6. Was the stay in hospital for the purpose of cosmetic or elective surgery?

Yes

No

If yes, please give details

7. Please specify the exact time and date of admission and discharge.

Admission: Time : Date

Discharge: Time : Date



Please sign and date.

Signature:
X

Date:

Hospital stamp:

Zurich Life Assurance plc

Zurich House, Frascati Road, Blackrock, Co. Dublin, A94 X9Y3, Ireland.

Telephone: 01 283 1301 Fax: 01 283 1578 Website: www.zurich.ie

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