ZURICH

Individual Permanent Health Insurance

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**

Please answer all questions carefully. Failure to provide full information may delay claim consideration.

Please return this form three months before the end of the deferred period.

Life Insured

Policy Number

Email Address

A Personal Details

Name

Address

Date of Birth　　Sex　M　F

Marital Status　Married/Civil Partner　Single　Separated　Widow(er)　Divorced/Former Civil Partner

Contact Number

Email Address

1. Please describe in full detail the exact nature of your occupation.

2. Please describe your normal daily duties.

B Medical Details

1. (a) Please state the exact nature of the incapacity from which you are suffering.

(b) In what way does this incapacity prevent you from following your occupation?

(c) Are you currently capable of carrying out your occupation on a part-time basis? If so please give details.

Continued overleaf

B Medical Details (continued)

(d) Which duties can you still perform?

2. Please give the date on which symptoms first commenced

3. When did the incapacity cause you to cease working?

4. (a) When do you expect you will be fit enough to return to work?

   (b) On a full time basis

   (c) On a part time basis

5. Please give details of any previous period of disability due to this or any other cause.

6. (a) Name and address of your usual Medical Attendant.

   Name

   Address

   Contact Number

   (b) Have you consulted them in respect of your present incapacity? Yes No

   If "Yes" please supply: Date of first attendance

   Date of most recent attendance

7. Have you consulted any other doctors or attended hospital as an in-patient or as an out-patient? Yes No

   If yes, please supply their names and addresses and date of first and most recent attendance.

8. (a) What treatment are you currently receiving?

   (b) Who prescribed this treatment?

C Financial details

1. Are you Self-Employed or a Share-Owning Director of the Company that employs you? Yes No
   If 'yes' please answer questions (a) to (c) below. If 'no' please proceed to question 2.

(a) How many employees does the business have?

(b) Will the business continue to function in your absence? Yes No

(c) What portion of your income will continue while you are disabled?

2. Please state your PPS Number and your P.R.S.I. Class:

PPS. Number: P.R.S.I. Class:

3. While absent from work, have you engaged in any other occupation, either on a full or part-time basis? Yes No
   If "Yes", please give full details:

(a) Please state your salary or gross earnings over the 12 months immediately prior to commencement of your disability:

€

(b) How much of your earnings have you lost as a result of your disability?

(c) Are you entitled to sick pay? Yes No

If "Yes", how much and when does it cease?

(d) Does any other part of your earnings continue during disability? Yes No

If "Yes", please give full details:

4. Are you claiming or entitled to claim sickness or accident benefit from any of the following? Yes No
   If so, please give details.

(a) Another Insurance Company?

(b) State Disability Benefit?

(c) Retirement Benefit?

(d) Any other source?

5. Please give any other information which may be of assistance in assessing this claim:

D 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.

For the purpose of data protection legislation Zurich Life is the data controller. Information on how Zurich Life collects, stores, and processes data can be obtained in its Privacy Statement which is available at www.zurich.ie/privacy-statement.

By signing this form I confirm that I have read and understand the Privacy Statement.

Name:
(Please Print)

Please sign and date.

Signature:
X

Date:

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