ZURICH

Personal Accident Income Benefit

Part 1: To be completed by the Life Insured and returned immediately
Please answer all questions fully. Failure to provide full information may delay claim consideration.

POLICY NUMBER

LIFE INSURED

Please specify

◯ Mr ◯ Mrs ◯ Ms ◯ Other

Forename:

Surname:

Address:

Telephone No.:

Email Address:

Date of Birth:

Please note: A claim will only be considered if your incapacity is as a direct result of an accident.

1. (a) Please describe your injury/incapacity.

(b) Have you previously suffered from this type of injury/incapacity? ◯ Yes ◯ No

If yes, please provide the dates this happened.

Continued overleaf

2. Did your injury/incapacity happen as the result of an accident? ◯ Yes ◯ No

3. If your injury/incapacity is the result of an accident, please describe in detail the circumstances surrounding this accident.

4. (a) What date did this accident occur?

   (b) In which country did this accident occur?

   (c) Were the police called to the scene of the accident? ◯ Yes ◯ No

   If yes, please provide name & rank of the attending Garda.

   (d) Was an ambulance present at the scene of the accident? ◯ Yes ◯ No

   If yes, please confirm the name and address of the hospital brought to.

   (e) If injury occurred as the result of a road traffic accident, please confirm the details and registration of your vehicle?

   (f) Is an insurance claim being processed by your motor insurance company? ◯ Yes ◯ No

   If yes, please advise the name of the motor insurer and policy number.

5. Please give full details as to how this injury/incapacity prevents you from following your occupation.

Continued overleaf

6. (a) Please describe in detail the exact nature of your occupation.

(b) Please advise if there are any manual duties involved in your job and if so please give a description of these duties.

(c) Has your occupation changed since proposing for insurance?

7. When did you cease performing your occupational duties?

8. When do you expect to be fit enough to return to work either on a full time or part time basis?

9. Please supply the name(s) and address(es) of all doctors you have attended in relation to this incapacity and the dates attended.

Name:

Address:

Date:

Name:

Address:

Date:

Continued overleaf

10. Are you currently claiming a Personal Accident benefit from any other Insurance Company? ◯ Yes ◯ No

If yes, please provide details of the Insurer, the amount of benefit payable and the date the benefit commenced.

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 Policy which is available at www.zurich.ie/privacy-policy.

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

Name: (Please Print)

Signature: **X**

Date:

Please sign and date.

Continued overleaf

Personal Accident Income Benefit

Part 2: To be completed by the insured's Employer, or by the Policyowner if self-employed and returned immediately.

LIFE INSURED

POLICY NUMBER

EMPLOYER DETAILS

Name:

Address:

Telephone No.:

Fax No.:

Email Address:

1. When did the employee commence his/her current occupation?
2. When did the employee cease working due to injury?
3. Until what date has the employee been certified unfit for work?
4. Please give full details of the duties the Life Insured is required to perform.
   (If a job description is available please provide a copy of same.)

Continued overleaf

5. (a) Please indicate which of these duties the insured can no longer perform.

(b) Please give full details of any manual tasks involved in the job.

6. What were the Insured's net **weekly** earnings at date of accident? €

7. When do you expect the employee to return to work?

DECLARATION

I/We declare that the above statements are true and complete.

I/we authorise the release, to Zurich Life, of any information, which Zurich Life considers relevant to enable this claim to be dealt with.

Name:
(Please Print)

Title:

Signature:
X

Date:

Please sign and date.

Company stamp:

Continued overleaf

ZURICH

Personal Accident Income Benefit

Part 3: To be completed by the doctor who certified the insured as unfit for work.

LIFE INSURED

POLICY NUMBER

1. Please describe the exact nature of your patient's injury.

2. Did this injury occur as a direct result of an accident? ◯ Yes ◯ No

   If yes, can you briefly describe the circumstances?

3. On what date did you first attend the patient for this injury?

4. Has your patient previously suffered from a similar incapacity? ◯ Yes ◯ No

   If yes, please provide details and dates of incapacity.

5. What is your patient's occupation?

Continued overleaf

6. Are they totally incapable of performing this occupation? ◯ Yes ◯ No

7. In what way does their current injury prevent them from being able to perform their occupation?

8. When do you expect the patient to be fit to return to work?

9. Have you referred the patient to a Consultant/Specialist for any tests or investigations? ◯ Yes ◯ No

   If yes, please advise full details.

Please sign and date.

Signature of attending doctor:
X

Date:

Qualifications:

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