ZURICH

Permanent Total Disablement

POLICY NUMBER

LIFE INSURED

Please specify

◯ Mr ◯ Mrs ◯ Ms ◯ Other

Forename:

Surname:

Address:

Telephone No.:

Date of Birth:

Email Address:

Please state your occupation:

SECTION 1

If you have any medical reports from your treating specialist or hospital relating to your recent diagnosis and treatment you should submit copies with your claim form. While the information may not be sufficient for us to make a decision on your claim it may be useful in helping us to assess your claim and avoid potential delays in getting reports from your specialist or GP.

1. Describe fully the nature and extent of your illness/disability.

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

Continued overleaf

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

5. (a) What symptoms preceded diagnosis of the illness?

(b) 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.

Continued overleaf

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? ◯ Yes ◯ No

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.

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

13. 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:

Please confirm the name and address of the Specialist being attended in relation to your illness.

Continued overleaf

14. Please describe all of your normal occupational duties in detail.

15. On what date were you first absent from work?

Have you been able to attend to any part of your occupation since this date? ◯ Yes ◯ No

If yes, please give details.

16. What aspects of your disability prevent you from following your occupation?

17. Do you anticipate returning to work? ◯ Yes ◯ No

If yes, when?

If no, why?

18. Do you intend seeking alternative employment? ◯ Yes ◯ No

If yes, please supply details.

19. Is there any aspect of your disability that will prevent you from working in any occupation? ◯ Yes ◯ No

If yes, please give full details.

20. Have you or do you intend to undergo any form of retraining or rehabilitation? ◯ Yes ◯ No

If yes, please supply details

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.

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