ZURICH

Surgical Cash Benefit

To be completed by the Life Insured. 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.:

Date of Birth:

Email Address:

1. Please describe the surgery you have undergone. Please first consult your Policy Document and specify exactly which surgery you are claiming under.

2. When did this surgery occur?

3. What symptoms did you have, and when did they first occur?

Continued overleaf

4. Did you have a general/spinal anaesthetic? ◯ Yes ◯ No

5. Please supply the name(s) and address(es) of your G.P.

Name:

Address:

6. Please supply the name and address of the referring doctors (if different).

Name:

Address:

7. Please supply the name and address of the Surgeon.

Name:

Address:

8. Please supply the name and address of any other doctors attended **and** reason for attendance.

Name:

Address:

Reason for attendance:

Where a valid claim is being paid we will pay the benefit directly into the Policy Owners bank account from which premiums are being paid. If you require payment to a different account please complete the details below and send a copy of the bank statement. Please note benefit can only be paid into a Policy Owners bank account.

PAYMENT DETAILS

Note: IBAN (International Bank Account Number) and BIC (Bank Identification Code) details are included on bank statements.

In the event of a valid admissable claim please complete so that the claim payment can be paid by Electronic Fund Transfer (EFT).

Account Holder Name(s):

Name of Bank/ Building Society:

IBAN:

Swift BIC:

Country Account is based in:

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)

Please sign and date.

Signature:
X

Date:

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