ZURICH

Serious Illness

PLEASE ANSWER ALL QUESTIONS FULLY. FAILURE TO DO SO WILL DELAY ASSESSMENT OF YOUR CLAIM.

POLICY NUMBER

LIFE INSURED

◯ Mr ◯ Mrs ◯ Ms ◯ Other Please specify

Forename:

Surname:

Address:

Telephone No.:

Email:

Date of Birth:

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. You can only submit a claim for Serious Illness Benefit if you have suffered from one of the **Critical Events** listed in your Policy Document. Please specify which *Critical Event* you are suffering from.

2. On what date did you first consult a medical practitioner in connection with your illness?

3. Was this your usual G.P.? ◯ 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 and the name of the doctor who performed them:

7. What treatment have you received, or are you currently receiving, in connection with your illness?

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 member of your immediate family suffered from a similar, or related, illness? ◯ Yes ◯ No

If yes, please state the relationship and nature of illness suffered.

Please state the date this illness was first diagnosed and please confirm the age(s) of the family member(s) when first diagnosed.

Continued overleaf

10. Do you smoke cigarettes? ◯ Yes ◯ No

Do you use electronic cigarettes? ◯ Yes ◯ No

If yes, what date did you commence smoking?

11. If you are not currently a smoker, 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?

12. 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 and start date of policy.

13. What is the name and address of your usual G.P.?

14. Please confirm the Name and Address of the Specialist being attended in relation to your illness.

15. 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:

Continued overleaf

16. Please give the names and addresses of any other doctors you have attended in the last five years for any reason and 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 I am the person referred to in the particulars given.

I understand that if any of these statements are knowingly or recklessly untrue my policy will be cancelled immediately and no benefit will be payable.

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 from any hospital in which I received treatment, or subsequently receive treatment, and I authorise the giving of such information.

I also authorise the release to Zurich Life of any information which the Company 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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