Terminal Illness

POLICY NUMBER

LIFE INSURED

Name

Address

Contact Number

Date of Birth

Sex ◯ M ◯ F

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

Email Address

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

SECTION 1

1. Please specify the illness you are currently suffering for which you are making this claim:

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

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

Continued overleaf

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/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 and start date of policy.

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

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

14. 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

15. 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.

16. Can you please confirm the name of the doctor who has confirmed you are suffering from a Terminal Illness for which the life expectancy is less than twelve months.

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
Please sign and date.

Signature
X

Date

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