ZURICH

Serious Illness of a child

POLICY NUMBER

POLICY OWNER(S)

Please specify

◯ Mr ◯ Mrs ◯ Ms ◯ Other

Forename:

Surname:

Address:

Name of Child:

Date of Birth of Child:

Email Address:

1. A claim for Serious Illness Benefit can only be submitted if a **Critical Event** has been suffered as listed in your Policy Document. Please specify which *Critical Event* you are claiming for.

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

(b) What date did they commence?

3. On what date did the child first consult a medical practitioner in connection with this illness/disability?

Continued overleaf

4. Was this the child's usual medical attendant? ◯ Yes ◯ No

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

Name:

Address:

6. Have any tests or investigations been carried out 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 was or is currently being given, in connection with this illness/disability?

8. Has the child 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. Is the condition your child is suffering from the result of a congenital defect?

10. Has any immediate family member 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

11. Please provide full details of any other insurance policies under which payment may be made for this condition, stating the name of the insurer, the policy number and amount of benefit.

Insurer:

Policy Number:

Amount of benefit:

12. What is the name and address of the child's usual medical attendant?

Name:

Address:

13. Please confirm fully the name and address of the Specialist being attended in relation to the child's illness.

Name:

Address:

14. Has the child attended 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 and reason for attendance.

Name:

Address:

Date(s):

Reason(s) for attendance:

Name:

Address:

Date(s):

Reason(s) for attendance:

Continued overleaf

DECLARATION

I declare that the above statements are true and complete and that I am the parent/legal guardian of the named child. In order to process this claim, I acknowledge that it may be necessary for Zurich Life Assurance plc ('Zurich Life') to seek the information from any doctor who has attended the child or any hospital in which the child has received or subsequently receives 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 the 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.

First Life Insured

Name:
(Please Print)

Please sign and date.

Signature:
X

Date:

Second Life Insured

Name:
(Please Print)

Please sign and date.

Signature:
X

Date:

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