

Hospital Cash Benefit

LIFE INSURED								
PC	POLICY NUMBER							
EMAIL ADDRESS								
1.	Please state the exact nature of the illness/disease/injury for which you are/were hospitalised.							
	Please confirm the date that you first attended a doctor for this condition.							
2.	What were your symptoms?							
	What date did they first start?							
3.	Please give details of all surgery/treatment/procedures undertaken.							
4.	Have you previously suffered from this or any related condition? Yes No							
	If yes, please give details.							

Continued overleaf

5.	What is the name and address of your usual doctor?						
	Name: Address:						
6.	Please specify the	charge.					
	Admission:	Time		Date			
	Discharge:	Time		Date			
7.	7. Please give the name and address of the hospital and the name of the doctor(s) attended there.						
Hospital: Doctor(s) attended:							
	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, who 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.						
	he Privacy Policy.						
	Name: (Please Print)						
	Signature:			Date:			



Please sign and date.

Continued overleaf



Certificate of Hospitalisation

LI	LIFE INSURED								
P	POLICY NUMBER								
E	EMAIL ADDRESS								
1.	Please state the exact diagnosis of the condition for which the patient attended hospital.								
2.	2. Was there any underlying illness? If so, please give details including any previous history.								
3.	. Please detail all surgery/treatment/procedures undertaken.								
4.	. What was the date of the first consultation for this condition?								
5.	. Please advise the name and address of the referring doctor.								
	Name:								
	Address:								
6.	. Was the stay in hospital for the purpose of cosmetic or elective surgery? Yes	No							
	If yes, please give details								

	7. Please spec	7. Please specify the exact time and date of admission and discharge.						
	Admissio	n: Time	:	Date				
	Discharge	: Time	:	Date				
Please sign and date.	Signature: X Hospital stamp	p:		Date:				

Zurich Life Assurance plc Zurich House, Frascati Road, Blackrock, Co. Dublin, Ireland. Telephone: 01 283 1301 Fax: 01 283 1578 Website: www.zurich.ie Zurich Life Assurance plc is regulated by the Central Bank of Ireland.

