

GROUP PERMANENT HEALTH INSURANCE

Employer's Claim Form



Note:

To be completed
by the Employer.

EMPLOYEE DETAILS

Please specify

Mr Mrs Ms Other

Forename:

Surname:

Address:

Occupation:

EMPLOYER DETAILS

1. Employer's Name and Address:

2. Date of joining company:

Date of joining Scheme:

3. Is he/she employed on a full-time permanent basis? Yes No

4. If not please state nature of contract:

5. Can you please supply precise details of Employee's duties, (if a job description is available, can you please attach a copy):

6. Nature of Disability:

Continued overleaf

7. What duties can the employee still perform?

8. Normal retirement age:

Start of continuous sick leave:

9. Basic Annual Salary at date of continuous absence: €

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 admissible claim please complete so that the monthly disability benefit 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

We declare that the above statements are true and complete, that the above named employee has not returned to work since the date of commencement of absence and that the sole reason for this absence has been the disability specified above.

Name:
(Please Print)

Staff Title:

Signature:

X

Date:

Company Stamp:


Please sign and 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
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