GDPR (General Data Protection Regulation)

Claims Form

Individual Permanent Health Insurance

ZURICH®

Policy Number	
Life Insured	

Please answer all questions carefully. Failure to provide full information may delay claim consideration.

Please return this form three months before the end of the deferred period.

A Policy Owner's Details

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.

B Medical Details

1. (a) Please state the exact nature of the incapacity from which you are suffering:

(b) In what way does this incapacity prevent you from following your occupation?

(c) Are you currently capable of carrying out your occupation on a part-time basis? If so please give details.

B Medical Details (continued)

(d) Which duties can you still perform?

3. Please give the date on which symptoms first commenced

4. When did the incapacity cause you to cease working?

5. (a) When do you expect you will be fit enough to return to work?

(b) On a full time basis

(c) On a part time basis

6. Please give details of any previous period of disability due to this or any other cause.

7. (a) Name and address of your usual Medical Attendant.

Name

Address

Contact Number

(b) Have you consulted them in respect of your present incapacity? ◯ Yes ◯ No

If "Yes" please supply: Date of first attendance

Date of most recent attendance

8. Have you consulted any other doctors or attended hospital as an in-patient or as an out-patient? ◯ Yes ◯ No

If yes, please supply their names and addresses and date of first and most recent attendance:

9. (a) What treatment are you currently receiving?

(b) Who prescribed this treatment?

C Financial details

1. Are you Self-Employed or a Share-Owning Director of the Company that employs you? ◯ Yes ◯ No
   If 'yes' please answer questions (a) to (c) below. If 'no' please proceed to question 2.

(a) How many employees does the business have?

(b) Will the business continue to function in your absence? ◯ Yes ◯ No

(c) What portion of your income will continue while you are disabled?

2. Please state your PPS Number and your P.R.S.I. Class:

PPS. Number: P.R.S.I. Class:

3. While absent from work, have you engaged in any other occupation, either on a full or part-time basis? ◯ Yes ◯ No
   If "Yes", please give full details:

(a) Please state your salary or gross earnings over the 12 months immediately prior to commencement of your disability:

€

(b) How much of your earnings have you lost as a result of your disability?

(c) Are you entitled to sick pay? ◯ Yes ◯ No

If "Yes", how much and when does it cease?

(d) Does any other part of your earnings continue during disability? ◯ Yes ◯ No
If "Yes", please give full details:

4. Are you claiming or entitled to claim sickness or accident benefit from any of the following?
   If so, please give details.

(a) Another Insurance Company?

(b) State Disability Benefit?

(c) Retirement Benefit?

(d) Any other source?

C Financial details (continued)

5. Please give any other information which may be of assistance in assessing this claim:

B 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

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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