ZURICH

Permanent Total Disablement

POLICY NUMBER

LIFE INSURED

Please specify

◯ Mr ◯ Mrs ◯ Ms ◯ Other

Forename:

Surname:

Address:

Telephone No.:

Date of Birth:

Please state your occupation:

SECTION 1

If you have any medical reports from your treating specialist or hospital relating to your recent diagnosis and treatment you should submit copies with your claim form. While the information may not be sufficient for us to make a decision on your claim it may be useful in helping us to assess your claim and avoid potential delays in getting reports from your specialist or GP.

1. Describe fully the nature and extent of your illness/disability.

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

Continued overleaf

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

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.

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.

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

13. 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:

Please confirm the name and address of the Specialist being attended in relation to your illness.

Continued overleaf

14. Please describe all of your normal occupational duties in detail.

15. On what date were you first absent from work?

Have you been able to attend to any part of your occupation since this date? ◯ Yes ◯ No

If yes, please give details.

16. What aspects of your disability prevent you from following your occupation?

17. Do you anticipate returning to work? ◯ Yes ◯ No

If yes, when?

If no, why?

18. Do you intend seeking alternative employment? ◯ Yes ◯ No

If yes, please supply details.

19. Is there any aspect of your disability that will prevent you from working in any occupation? ◯ Yes ◯ No

If yes, please give full details.

20. Have you or do you intend to undergo any form of retraining or rehabilitation? ◯ Yes ◯ No

If yes, please supply details

DECLARATION

I declare that the above statements are true and complete and that I am the person referred to in the particulars given. I consent to Zurich Life seeking 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.

Zurich Life Assurance plc ('Zurich Life') is a member of Zurich Insurance Group ('the Group'). In order to provide a seamless insurance service globally, Zurich Life may transfer any data it has received from, and any data it holds on me to other units of the Group, such as branches, subsidiaries, or affiliates within the Group, cooperative partners of the Group, coinsurance and reinsurance companies located in this country or abroad. Zurich Life, as well as such recipients may use, process and store the data, in particular for the purpose of risk evaluation, policy execution, premium setting, premium collection, claims assessment, claims processing, claims payment, statistical evaluation or to otherwise ensure the Group global insurance service delivery.

If a Financial Advisor or agent is acting on my behalf, Zurich Life is authorised to use, process and store data received from such Financial Advisor or agent, and to forward to such Financial Advisor or agent my data relating to the execution of the policy, collection of premiums and payment of claims. Zurich Life will not release or share any confidential medial information with my Financial Advisor.

Zurich Life may procure data from third parties including private investigators to assess a claim. Zurich Life may check my personal data against international / economic or financial sanctions, laws or regulated listings.

You have a right of access to and the right to rectify the data concerning you held by Zurich Life.

Name: (Please Print)

Signature:
X

Date:

Please sign and date.

Zurich Life Assurance plc
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