



ZURICH[®]

Waiver Of Premium Benefit

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

[illegible]

B Personal Details

Name																		
Address																		
Date of Birth																		
Sex	☐	M	☐	F														
Marital Status	☐	Married/Civil Partner	☐	Single	☐	Separated	☐	Widow(er)	☐	Divorced/Former Civil Partner								
Contact Number																		
Email Address																		

1. Please describe in full detail the exact nature of your occupation.

2. Please describe your normal daily duties.

C Medical Details

1. Please state the exact nature of the incapacity from which you are suffering.

2. (a) In what way does this incapacity prevent you from following your occupation?

(b) Which duties can you still perform?

C Medical Details (continued)

3. Please give the date on which symptoms first commenced

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

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

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

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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

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Date of most recent attendance

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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:

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

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(b) Who prescribed this treatment?

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D 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)

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Signature

X

Date

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 **Signature**
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

Zurich Life Assurance plc is regulated by the Central Bank of Ireland.

The information contained herein is based on Zurich Life's understanding of current Revenue practice as at May 2018 and may change in the future.

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