Serious Illness Claim Form

Policy Number:		**Life Insured:**	
Telephone Number:	_____	**Address:**	_____
Occupation:	_____	**Date of Birth:**	_____

Section 1

1. You can only submit a claim for Serious Illness Benefit if you have suffered from one of the *Critical* Events listed in your Policy Document. Please specify which *Critical Event* you are suffering from.

_____
_____
_____

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

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

_____
_____

5. What symptoms preceded diagnosis of the illness and 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.
_____
_____
_____

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?
_____

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 and amount of benefit.
_____
_____
_____

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

13. Please confirm the Name and Address of the Specialist being attended in relation to your illness.
_____
_____
_____

14. 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

_____
_____
_____

15. Please give the names and addresses of any other doctors you have attended in the last five years for any reason.

_____
_____
_____
_____
_____

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

I understand that if any of these statements are knowingly or recklessly untrue my policy will be cancelled immediately and no benefit will be payable.

I consent to Zurich Life Assurance plc seeking information from any doctor who has attended me, or subsequently attends me, or from any hospital in which I received treatment, or subsequently receive treatment, and I authorise the giving of such information.

I also authorise the release to Zurich Life Assurance plc. of any information which the Company considers relevant to enable my claim to be dealt with.

Signed _____ ***Date*** _____