



Absence from Work / Accidental Injury Claim Form

We are here to support you through this process to make it as simple and hassle free as possible. If you have any questions or concerns about completing this form, our experienced claims assessors will be happy to help. You can phone us on 01 617 2974 or email us at claim@newireland.ie

Policy Number:

Important Information:

- Please answer all questions on this form, fully, honestly and carefully as this will help us process your claim faster and avoid any delays. It's important to know that your insurance policy could be cancelled from the start and your claim not accepted if there is any misrepresentation or failure to provide requested information by or on behalf of the Policyholder, or a Life Insured.
- We take your privacy seriously. It is important that you know how we protect and use your data. Please refer to the "Data Protection" section at the end of this document for further information regarding this.
- Please note that this form is used to gather information to help us assess your claim and is not an admission of liability by New Ireland Assurance. Once we receive your claim form, along with copies of the documents we list below, we will assess your claim and contact you when we have finished this process, either by letter, email or phone.
- Please complete this form using BLOCK CAPITALS and use a tick (✓) where appropriate. If you need to add extra details to your answers, you can use a separate sheet.
- Please note that for payment to be made to one policy owner only, in the case of a joint or dual life policy, both policy owners must sign and accept the payment instruction in Section 5.

What do I do next?

- When you have completed this form, you can send it back to us, along with your supporting documents, by post to; Risk Claims Department, New Ireland Assurance, 5-9 South Frederick Street, Dublin 2. or by email to claim@newireland.ie
- Please include the following documents with your claim form and tick (✓) the boxes to confirm when you have done this:

Proof of Income:

For people who are Employed: a copy of your three most recent payslips before your accident / illness.

For people who are Self-employed: a copy of your most recent Form 11 or alternatively, a letter from your Accountant confirming your average weekly earnings over the past year.

Job Description - if you have a copy of your job description, please include this for our records.

Section B - please make sure that your doctor has filled in Section B of this form.

- As always, please make sure that if you are sending personal data (especially special category data like medical information) by email, always take care to protect this information by using a password or encrypting your email.

1. Claimant details The following section should be filled out by the Life Assured (person making this claim)

Name(s):

Address & Eircode:

Date of Birth:

D	D	M	M	Y	Y	Y	Y

Home Telephone Number:

Mobile Telephone Number:

Email:

2. Occupational details

The information in the following sections is needed to assess the validity of your claim and to assess any potential misrepresentation relevant to the claim and /or any policy (contract) you may have /be included in with New Ireland Assurance. Please answer all of the questions fully, honestly and carefully. There is no need to tell us, New Ireland Assurance, about genetic tests that have been carried out and New Ireland Assurance will not consider the results of any genetic tests we receive.

What is your current occupation?

Name and address of your current employer:
(Please state self-employed if this is the case)

Please give a detailed description of your normal working duties, i.e what are the main day-to-day duties or tasks you perform in your role including any physical work you do?

What type of environment do you normally work in? (For example; office, factory, outdoors, home office etc.)

How many hours per week do you normally work?

When did you last perform any part of your occupation?

D	D	M	M	Y	Y	Y	Y

When do you expect to be able to return to work or carry out any part of your occupation?

D	D	M	M	Y	Y	Y	Y

If you have already returned to work, please advise the date of your return:

D	D	M	M	Y	Y	Y	Y

Have you carried out any other work (whether paid or unpaid) since your accident/illness?

Yes No

If yes, please give details of what work you have carried out and the dates the work was carried out:

3. Your medical details

Please describe the extent and nature of your illness or injury related to this claim:

If you are claiming for an injury, please give:

Date of accident:

D	D	M	M	Y	Y	Y	Y

Date medical advice first requested:

D	D	M	M	Y	Y	Y	Y

Please give details on the circumstances of the accident:

If claiming for an illness, please give:

Date your symptoms first appeared:

D	D	M	M	Y	Y	Y	Y

Date medical advice first requested:

D	D	M	M	Y	Y	Y	Y

Have you had this injury/illness before?

Yes No

If yes, please give details including; the names of your Doctor/Hospital and the dates you consulted with them.

3. Your medical details (continued)

Please give the name and address of the doctor you first attended with this condition:

--

Name and address of your regular GP (General Practitioner/Family Doctor): (If different from above)

--

Date of last attendance:

D	D	M	M	Y	Y	Y	Y

Date of next attendance:

D	D	M	M	Y	Y	Y	Y

Please give the name and address of any other doctors or specialists you have seen in connection with this condition:

--

Date of last attendance:

D	D	M	M	Y	Y	Y	Y

Date of next attendance:

D	D	M	M	Y	Y	Y	Y

Are you waiting on any referrals for tests or consultations?

Yes No

If yes, please give details including the types of tests/consultations you are being referred for.

--

Does this condition prevent you from performing all of the duties/activities of your job?

Yes No

If no, please give details including what duties/activities you can perform for your job?

--

4. Bank account details

When the claim has been admitted and processed, please pay the proceeds by EFT (Electronic Fund Transfer) to the person below:

Account Holder Name(s)*:

Account Number (IBAN):

Swift BIC:

(your bank will be able to confirm these details if necessary)

Bank Name:

Bank Address:

* Payments may only be made to either one or both policy owners.

Please note that payments from New Ireland Assurance will only start if your claim is accepted.

5. Declaration and agreement to seek further information

I confirm that I have:

- read and understood all the questions asked on this form, and
- answered the questions on this form fully, honestly and carefully whether completed by me or on my behalf.

I agree to New Ireland Assurance asking for Information (including Medical Information) from any doctor or health professional who at any stage has attended me and from any insurance office to which an application has been made on my life and I authorise them to give New Ireland Assurance the Information asked for. I understand that only Information necessary to assess the validity of a claim or to assess any potential misrepresentation relevant to the claim and /or any policy (contract) I may have / be included in with New Ireland Assurance will be asked for.

I agree to New Ireland Assurance arranging Independent Medical Examinations as part of the assessment of my claim and I authorise the sharing of my Medical Information with medical professionals for this purpose.

I agree to and authorise New Ireland Assurance exchanging Medical Information with my doctor in the event it becomes necessary to do so in order to help New Ireland Assurance assess the claim or to explain a claim decision.

I agree to New Ireland Assurance seeking relevant Information necessary for the assessment of this claim and/or for the assessment of any potential misrepresentation relevant to the claim and/or any policy (contract) I may have/be included in with New Ireland Assurance from my employer and I authorise them to give New Ireland Assurance the Information asked for.

I understand that I must notify New Ireland Assurance immediately if I resume my normal occupation on a full time or part time basis, or if I take up alternative work (whether paid or unpaid) as failure to do so will result in my claim being rejected or payment being terminated and cover ceasing.

I understand the Information provided in this form and any other Information received in connection with this claim may be held by New Ireland Assurance and its duly authorised agents on computer file, in any other dematerialised form or in written hard copy and may be used or passed to third parties (including where relevant, specialist or private investigators) for matters in connection with the investigation and processing of this claim and /or matters in connection with the investigation of any potential misrepresentation relevant to the claim and / or any policy (contract) I may have /be included in with New Ireland Assurance and for administration, regulatory, statistical analysis, market research, customer care and service purposes.

I agree that New Ireland Assurance, or a duly authorised agent of New Ireland Assurance, may contact me in person, by phone, by email, or by letter in relation to the processing and management of this claim.

I understand that the Information provided to New Ireland Assurance as part of my claim will be processed by New Ireland Assurance and its duly authorised agents to:

- assess and review my claim,
- investigate and assess any potential misrepresentation relevant to the claim or the policy (contract) including any other policy (contract) that I may have/be included in with New Ireland Assurance.


I understand that in certain cases, this may involve the sharing of my Information with other insurance providers and private investigators.


I understand that New Ireland Assurance reserves the right to instruct a private investigator to investigate a claim.

I understand that if any questions are not answered fully, honestly and carefully then New Ireland Assurance may:

- cancel the policy from the start and/or
- refuse to pay any claim and/or
- reduce the amount of any claim and/or
- reduce the amount of cover

Please read the Data Protection wording at the end of this form.

	Signature of Claimant/Owner:	Date:															
	<input type="text"/>	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>	D	D	M	M	Y	Y	Y	Y							
D	D	M	M	Y	Y	Y	Y										

	Signature of Joint Policy Owner*:	Date:															
	<input type="text"/>	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>	D	D	M	M	Y	Y	Y	Y							
D	D	M	M	Y	Y	Y	Y										

* We require all policy owners to sign the claim form in order for the payment instruction to be carried out as above.

6. Data Protection

This section gives you a summary of how New Ireland Assurance Company plc (New Ireland) will use and process your Information. New Ireland is a life assurance and pensions company registered in Ireland.

New Ireland's contact details are as follows:

Address: 5-9 South Frederick Street, Dublin 2.

Telephone: (01) 523 9810

Email: info@newireland.ie

Website: www.newireland.ie

New Ireland's Data Protection Officer's contact details are as follows:

Address: Data Protection Officer, New Ireland Assurance, 5-9 South Frederick Street, Dublin 2.

Email: dataprotection@newireland.ie

As you read this section there are some terms that are important for you to understand.

"Information" means any personal data and/or information including health and non-health information given by you or on your behalf in connection with this Claim or any further information which may be given at a later stage in relation to the policy (contract) either in writing, by email, at a meeting or over the telephone including information contained in records of your transactions with New Ireland.

"EEA" means the European Economic Area and consists of the EU Member States as well as Norway, Iceland and Liechtenstein.

"Marketing" means direct marketing and cross-selling of New Ireland's services and/or products provided by New Ireland or arranged by New Ireland with a third party.

What will we use your Information for?

The Information being collected on this form and any related document is for the purposes of processing your claim under the contract. We may not be able to process your claim without the information collected on this form. Processing can include dealing with your Information to enable us comply with legal and regulatory requirements and/or using the Information to assess and deal with any claim you make and/or to assess any potential misrepresentation relevant to the claim and /or any policy (contract) you may have / be included in with New Ireland Assurance. We will also use your Information where we legitimately need to do so to operate our business but this won't adversely impact on your fundamental rights. If you omit or do not provide the Information requested, if the Information provided is not true and/or complete or if you later request the Information be amended or erased, then you may not be able to proceed to take out a contract, any existing contract you have with us may cease and/or you may not be able to receive benefits under an existing contract.

The Information may be processed and disclosed to other parties as set out below. In some circumstances we will need to disclose the Information to relevant third parties (e.g. to meet Revenue or regulatory requirements). Where we have asked you to consent to us using your Information, we will only use it in accordance with the consent you provide.

Our Data Privacy Notice contains more details about how we process your Information. A copy is available on our website.

Alternatively we would be happy to provide you with a copy at any time. Please contact us at the details set out above.

New Ireland and its duly authorised agents can:

- contact you by letter, phone, SMS, email or other electronic means in relation to the administration (including any review) of the contract you have entered into. This may include contacting you to provide you with general information relating to the contract at any time;
- hold and use the Information on computer file, in any other dematerialised form or in written hard copy on its own behalf and on behalf of other companies within the Bank of Ireland Group;
- use or pass the Information to third parties for administration, regulatory, customer care and service purposes in relation to the contract. This includes;

- | | |
|---|--|
| <ul style="list-style-type: none">• Reinsurance Companies• Mail Services Companies• Information Technology Companies• Brokers/Intermediaries• Auditors and Accountants• Pensions Authority• Research Partners• Revenue Commissioners• Employers | <ul style="list-style-type: none">• Trustees• Claims handlers• Third Party Service providers including medical screening, administrators, private investigators and other service operators• Financial institutions/payment service providers |
|---|--|

- disclose and/or transfer the Information to other countries, including countries outside of the EEA for any of the purposes specified in connection with the administration of the contract, to persons including entities who have been approved by New Ireland and in a manner compliant with applicable data protection legislation. The Information may be transferred to countries in respect of which the European Commission has not made an adequacy decision, however the transfer of Information will be made on the basis that appropriate safeguards including standard data protection clauses have been put in place. You may obtain a copy of these clauses by writing to New Ireland at the address stated above;
- use your Information to carry out statistical analysis and market research including for distribution quality management purposes and to determine product/campaign offerings and requesting your feedback to help improve our service;
- hold and store the Information for a period of time in accordance with a number of factors including to comply with;
 - any contractual obligations, including the type of contract or service we have provided.
 - any legislative or regulatory rules or codes set by authorities such as the Central Bank of Ireland, the Data Protection Commission, Revenue Commissioners, Government agencies.
 - the resolution of a legal or some other type of dispute.

6. Data Protection (continued)

- for certain types of contracts (e.g. life assurance protection contracts) make decisions based on automated processing including profiling. Where this is taking place you will have the right to obtain human intervention where you wish to express your point of view and/or contest the decision that is made.

You acknowledge that subject to certain conditions as set out in legislation you have the following rights in relation to the Information you have provided:

- You may request access to and/or rectification or erasure of the Information.
- You may restrict New Ireland from processing the Information.
- You may object to New Ireland processing the Information for certain purposes.
- You have the right to receive your information in a structured, commonly used and machine readable format (data portability).
- You understand that you have the right to lodge a complaint with the Data Protection Commission.

Section B: The following section should be filled out by your GP

Medical details

Policy Number:

Life Assured: (person claiming)

What is the nature of this patient's current illness /injury?

Was this illness/injury a direct result of an accident?

Yes No

If yes, please give details on the circumstances of the accident.

When did your patient first attend you with this illness/injury?

D	D	M	M	Y	Y	Y	Y

Did your patient ever suffer from this or a similar illness /injury before?

Yes No

If yes, please give details on the extent and nature of any previous injury/illness

Is your patient currently able to work:

On a full-time basis On a part-time basis Not at all

If you feel that this patient is unable to return to work , please explain what factors are preventing them from doing so:

What treatment is your patient currently receiving?

When do you expect your patient will be able to return to work (either on a part-time or full-time basis)?

D	D	M	M	Y	Y	Y	Y

Please give the dates that you are certifying this patient as unable to work:

From:

D	D	M	M	Y	Y	Y	Y

 To:

D	D	M	M	Y	Y	Y	Y

Have you referred this patient for any tests or investigations?

Yes No

If yes, please give details.



Signed:

Position held:

Date

Signed:

D	D	M	M	Y	Y	Y	Y

Practice Stamp

New Ireland Assurance Company plc.,

5-9 South Frederick Street, Dublin 2.

T: (01) 617 2974 F: (01) 617 2050.

E: claim@newireland.ie W: www.newireland.ie

New Ireland Assurance Company plc is regulated by the Central Bank of Ireland. A member of Bank of Ireland Group.

302114 V8.08.21