NEW IRELAND ASSURANCE

Broken Bones
Claim Form

- Please complete in **BLOCK CAPITALS** and tick (✓) where appropriate
- Please answer all questions fully to avoid any undue delay in considering your claim.
  If you fail to disclose all relevant information or if you give false information you could render your insurance void.
- Please note this form is not an admission of liability by New Ireland Assurance. On receipt of your claim form we will assess your claim and we will communicate with you when this process has been completed.
- Please return this form to: Claims Department, New Ireland Assurance, 11-12 Dawson Street, Dublin 2.
  Tel: 01 617 2974. Fax: 01 617 2050. Email: claim@newireland.ie
  Please ensure if sending personal data (especially sensitive personal data i.e. medical information) by email that appropriate security measures (including encrypting the data) are taken to comply with relevant regulatory obligations.

Policy Number:

Section A - To be completed by the Life Assured making this claim

1. Claimant details

Name:

Address:

Date of Birth: D D | M M | Y Y Y Y

Telephone Number:

Occupation:

2. Medical details

Date of Accident: D D | M M | Y Y Y Y

Place of Accident:

Nature of Injury:

Details of Accident:

Date medical advice first requested: D D | M M | Y Y Y Y

Have you previously suffered from a fracture of this bone / dislocation of this joint? ☐ Yes ☐ No

If yes, please advise the details to include dates.

Please advise the name and address of the doctor you first attended for this injury:

Please advise the name and address of your usual GP: (If different from above)

3. Payment details

Following the admittance of the claim please pay the proceeds to the person shown below.

By EFT payment to the following bank account*

Account Holder Name(s)†:

Account Number (IBAN):

Swift BIC:

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

Bank Name:

Address:

* Please note that payment by EFT is not possible for some policy types.

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

Please note that payments will only commence to be made following acceptance of your claim by New Ireland Assurance.

4. Additional requirements

Please enclose copies of any medical reports or test results you have in connection with this injury

5. Declaration and consent to seek further information

I hereby declare that, to the best of my knowledge, all answers given by me on this claim form are true and complete.
I consent to New Ireland Assurance Company plc seeking any medical information from any doctor who has at any time attended me and any information from any insurance office to which a proposal has been made on my life and I authorise the giving of such information to you.

I consent to New Ireland Assurance seeking any information necessary for the assessment of this claim from my Employer and I consent to the giving of such information to them.

I understand and consent that New Ireland and its duly authorised agents may hold and use the information on computer file, in any other dematerialised form or in written hard copy on its own behalf and may use or pass the information to third parties for administration, regulatory, customer care and service purposes. I agree that New Ireland or a duly authorised agent of New Ireland may contact me in person, by phone, by email or by letter.

"Information" means any information including medical and non-medical information given by me or on my behalf in connection with this claim or any further information which may be given at a later stage either in writing, by email, at a meeting or over the telephone.

Signature of Claimant:

Date: D D M M Y Y Y Y

Signature of policy owner (If different)*:

Date: D D M M Y Y Y Y

* 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 acceptance to the payment instruction outlined above.

Section B

To be completed by the doctor who attended the claimant for this injury

Patient Name: | **Date of birth:** D D M M Y Y Y Y

Date of Accident: D D M M Y Y Y Y

Date claimant first attended with this injury: D D M M Y Y Y Y

Place of Accident:

Nature and cause of accident:

Nature of injury sustained: (Please advise the exact location and type of the fracture / dislocation)

Is this injury related to any previous injury or illness the claimant had prior to this attendance? ☐ Yes ☐ No

If yes, please advise details to include dates of any previous injury/illness.

Please advise what x-rays / tests / investigations were carried out:

PLEASE ENCLOSE A COPY OF THE TEST RESULTS CONFIRMING THIS INJURY.

Please advise the results of these investigations in as much detail as possible:

PLEASE ENCLOSE A COPY OF ANY ADDITIONAL DOCUMENTATION ON FILE CONFIRMING THE DIAGNOSIS MADE.

Signed:

Position held:

Date Signed: D D M M Y Y Y Y

Practice / Hospital Stamp

New Ireland Assurance Company plc.,

11-12 Dawson Street, Dublin 2.

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

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