PENSIONS
INVESTMENTS
LIFE INSURANCE

Irish Life

ACCIDENT COVER CLAIM FORM – FRACTURES & DISLOCATIONS

Before you give us your personal information it is important that you know what your data protection rights are and how and why we use your personal information. This is set out in the Irish Life Data Privacy Notice which is always available on our website at www.irishlife.ie or you can ask us for a copy.

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Dear Claimant

Irish Life's philosophy is to pay all valid claims as promptly as possible. We are available to help and advise you at all stages of the claim process.

In order for us to consider your claim, we require the following:

A fully completed claim form:

- Section A: Must be fully completed by the claimant, signed & dated
- Section B: Must be fully completed by the treating claimant's doctor, signed & dated and stamped.

This claim form should only be completed if you are claiming for one of the Qualifying Injuries – please refer to the back page for the list of injuries covered.

On receipt of your completed claim form we will start the assessment process.

We need relevant personal health information to assess this claim. We may need to contact you if we need to clarify any information or ask you for further information. We may also need to get relevant personal health information in connection with this claim from GPs, consultants, hospitals or other health professionals. We may use the health information obtained at this claim for any subsequent claims and/or applications to Irish Life.

In certain circumstances we will use the service of Private Investigators. Each Private Investigator must adhere to a strict code of practice and complete a compliance certificate. They are expected to comply at all times with the Data Protection Law and not perform their functions in such a way as to cause Irish Life to breach any of its obligations under the Data Protection Law. Any unauthorised processing, use or disclosure of personal data by Private Investigators is strictly prohibited.

We will keep you informed if any further information is needed.

If you have any questions regarding this claim form or your benefits, you can contact our Protection Claims Team or our Customer Service Team.

Our contact details are as follows:

Protection Claims Team
Irish Life Assurance plc,
Irish Life Centre,
Lower Abbey Street,
Dublin 1.

Email: protectionclaims@irishlife.ie

Tel: 01 704 1855
(Lines open 9am – 5pm Monday to Friday)

Fax: 01 680 3387

Main Customer Service Centre

Phone: 01 704 1010

Email: protection@irishlife.ie

Our lines are open:
8am to 8pm Monday to Thursday
10am to 6pm Friday
9am to 1pm Saturday

In the interest of customer service we will record and monitor calls.

Send your claim form to:
Protection Claims Team
Irish Life Assurance plc
Lower Abbey St
Dublin 1

Please note that the issuing of this claim form is not an admission of liability for a claim.

Giving false information in this claim form could result in your cover being cancelled.

All questions must be answered. Please use BLOCK CAPITALS

Section A – To be completed by the claimant

Claimant Details

Name of Claimant

Plan number

Address

Date of Birth d d / m m / y y y y

Occupation

Phone number

Name of GP

Address of GP

Accident Details

1. Date of Accident d d / m m / y y y y Time of Accident

2. Place of accident

3. What were the circumstances of the accident, i.e. what were you doing at the time the injury was sustained?

4. How was your injury sustained?

5. What is the location of the fracture or dislocation?

6. Date of any period of hospitalisation (From – To, Name of Hospital)

7. What treatment did you receive?

8. If a dislocation, have you previously dislocated this joint? If yes, please give the date. Yes ◯ No ◯

   Date d d / m m / y y y y

Payment

In the event that your claim is admitted we can arrange for payment to be made in a number of ways. Please choose how you wish the claim to be paid by ticking the appropriate box:

1. If you wish to receive your payment by cheque please tick here ○
2. If you are currently paying your plan by direct debit and would like payment to be made to this bank account, please tick here ○
3. If you would like your payment to be made to another bank account in your name, please complete the section below and enclose a copy of a recent bank statement dated within the last 6 months. This statement should be for the account you wish payment to be made into and contain your name, address, BIC and IBAN and you should return it with this claim form. ○

Bank Identifier Code (BIC)

IBAN

Account Name:

Bank Name & Address:

Your BIC and IBAN details can be found on your bank statement. You can also request them directly from your bank. Important: Please note that the bank account details provided must be your own bank account or an account held jointly by you. Payment cannot be made to a third party or a third party bank account.

I/We wish to have our claim proceeds paid as above


Please sign and date

Your Signature ✗ Date d d / m m / y y y y

Joint Signature ✗ Date d d / m m / y y y y

Plan owner's signature ✗ Date d d / m m / y y y y

Declaration

I declare that all answers given by me in this statement are, to the best of my knowledge and belief, true and complete and that I am the person referred to in the particulars given.

I understand and agree that my claim with Irish Life Assurance plc (Irish Life) will be based on all personal and health information Irish Life hold from my applications and all personal and health information received for any claim.

I understand that if I provide false or deliberately inaccurate information on this form my cover may be cancelled.

I fully understand that I must notify Irish Life immediately if I resume my normal occupation either on a full time or part time basis, or if I take up alternative work whether paid or not, as failure to do so will result in my claim being rejected or payments being terminated and cover ceasing


Please sign and date

Signature ✗ Date d d / m m / y y y y

Authorisation

I authorise Irish Life to request and receive my personal health information from any GPs, consultants, hospitals or other health professionals who at any time has attended me concerning my physical or mental health and to share my personal health information with any health professional for the purpose of assessing my claim.


Please sign and date

Signature ✗ Date d d / m m / y y y y

Section B - to be competed by the claimant's Doctor

Claimant Details

Name

Occupation

How long have you been the claimant's medical attendant?

Injury Details

1. Date of Accident d d / m m / y y y y

2. Place of accident

3. Circumstances of the accident

4. Exact nature of injury sustained

5. Please provide the exact details of any bone fracture or joint dislocation?

6. Please confirm the date and results of all x-rays?

7. What treatment did the claimant receive? Please include details of medication, physical aids, physiotherapy and surgery carried out.

8. Is any further treatment planned? If so, please provide full details. Yes ◯ No ◯

9. Has the claimant previously suffered from a similar injury? If so, please provide full details. Yes ◯ No ◯

I certify that I have personally examined the claimant and that all foregoing statements are correct.

Please sign and date

Signature ✗

Date d d / m m / y y y y

Doctor Stamp

Qualifying Injuries

The following is the list of qualifying injuries covered under Accident Cover:

- Fracture of the upper leg
- Fracture of the lower leg or ankle
- Fracture of the arm
- Fracture of the wrist
- Fracture of the vertebrae, shoulder blade or sternum
- Fracture of the jaw or cheekbone
- Fracture of the foot
- Fracture of the ribs or collarbone
- Open fracture of the skull
- Closed fracture of the skull
- Dislocation of the hip
- Dislocation of the ankle
- Dislocation of the elbow
- Dislocation of the shoulder

Please note:

- Please refer to your plan terms and conditions for full details on the above fractures.
- Fractures to fingers, toes and nose are not covered.
- If you suffer multiple fractures as a result of a one accident, benefit will be paid once in respect of the qualifying injury which results in the highest claim payment.

Irish Life Assurance plc, Irish Life Centre, Lower Abbey Street, Dublin 1. **T**: 01 704 1010 • **F**: 01 704 1900
Irish Life Assurance plc, Registered in Ireland number 152576, Vat number 9F55923G.

Irish Life