NEW IRELAND ASSURANCE

Income Protection - 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:

1. Personal details

Name:

Address:

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

PPS Number:

Home Telephone No:

Mobile Telephone No:

Email:

Job Title:

2. Occupational Details

Please tick as appropriate:

Are you ☐ Self-Employed/Company Director (please start at question 1 below)

☐ Employed (please skip to question 2 below)

1. If you are Self Employed or a Company Director, please provide the name and address of your business.

A) Do you have any employees? ☐ Yes ☐ No

If yes, how many?

B) Has your business ceased operations? ☐ Yes ☐ No

C) Does your business continue to generate any income? ☐ Yes ☐ No

D) For how long have you been Self-Employed/Company Director Years Months

2. Name and address of your Employer at the time your disability commenced.

If you have answered Question 1 A - D Please skip to Question 4

3. How long have you been with your current employer? ☐ Years ☐ Months

4. Is your employment Full time ☐ Part time ☐ Job Share ☐

5. How many hours per week do you work? ☐ Hours

6. On what date did you last undertake any part of your job? D D M M Y Y Y Y

7. During an average working day, what % of time would you spend doing the following activities?

Sitting	☐ %	Typing	☐ %
Walking	☐ %	Lifting	☐ %
Bending	☐ %	Driving	☐ %
Other physical activity	☐ %	Please describe	

8. Please provide a description of your normal **working duties,** i.e. what are the main duties you have to perform in your role?

9. Are you still an employee of your company? ☐ Yes ☐ No
If no, please provide further details.

10. Is the job you were performing still open to you when you recover? ☐ Yes ☐ No
If no, please provide details.

11. Have you discussed future employment or rehabilitation with your employer? ☐ Yes ☐ No
If yes, please provide details.

12. When was your last contact with your employer?

13. On what date do you expect to be able to resume work? D D M M Y Y Y Y

14. Have you undertaken any other work (whether paid or unpaid) since commencement of disability? ☐ Yes ☐ No
If yes, please give full details.

15. Are you a director, stakeholder or on the board of any company? ☐ Yes ☐ No
If Yes, please confirm details of the role and relevant financial details in Section 3.

3. Financial Details

1. What were your gross taxable earnings in the 12 months immediately before your disability? €

2. Are you in receipt of any other income from any other sources? ☐ Yes ☐ No
   If "yes", please provide full details:

   A) Your employer
   B) A second job
   C) State Illness Benefit
   D) Other sources e.g. Airbnb

3. Do you have any other insurance policies where benefit becomes payable as a result of your inability to work? ☐ Yes ☐ No
   If "yes", please provide full details:

   Company Name
   Policy Number
   Sum Assured €
   Deferred Period

   Have you submitted a claim? ☐ Yes ☐ No

   Is this claim in payment? ☐ Yes ☐ No

Should you have more than one policy, please provide the details on the General Information section on page 5.

4. Medical Details

1. Please describe in detail the nature of the disability from which you are suffering, including any diagnosis.
   If your disability is the result of an accident, please provide details.

2. When did you first experience symptoms related to your disability and what were these symptoms?

3. Have you previously had the same or similar condition? ☐ Yes ☐ No
   If yes, please confirm dates and duration of illness.

4. Please provide details of any previous absences from work due to your illness/disability.

5. When did you first seek medical advice about your disability?

6. Please provide details of any medical investigations, either as an inpatient or outpatient, and any specialist referrals in respect of your disability.

7. What treatment, medication or therapy are you currently receiving? Please include dosage.

4. Medical Details Cont.

8. Is your current treatment providing any relief from symptoms? ☐ Yes ☐ No

If yes, please provide details.

9. Please describe the duties/activities relating to your normal occupation that you are unable to carry out as a result of your disability.

10. Please describe the duties of your normal occupation that you can still perform.

11. Details of doctors/specialists, in connection with this condition.

GP:

Name:

Address:

Contact No.:

Your main treating Consultant:

Name:

Area of Speciality:

Address:

Contact No.:

Date Last Attendance: D D M M Y Y Y Y

Date Next Attendance: D D M M Y Y Y Y

Consultants & any other medical practitioner attended:

Name:

Area of Speciality:

Address:

Contact No.:

Date Last Attendance: D D M M Y Y Y Y

Date Next Attendance: D D M M Y Y Y Y

12. Have you attended any other doctors in the last 5 years? (If yes, please provide details). ☐ Yes ☐ No

13. Have you, are you, or do you intend making a claim for compensation against a third party in respect of your disability? ☐ Yes ☐ No

If yes, please provide further details.

5. General Information

Please provide any additional information you feel would assist us in assessing you claim.

6. Bank Account Details

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

Account Holder Name:

Account Number (IBAN):

Swift BIC:

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

Bank Name:

Address:

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

7. Checklist

Please tick box to confirm that the requested information has been enclosed:

- ☐ A clear copy of photo ID in the form of a current passport or driver's licence
- ☐ A clear copy of proof of address in the form of a utility bill or bank statement dated within the last 6 months
- ☐ Detailed Job Description

For **Employed Persons** (no requirement if the confirmed income option has been chosen):

- ☐ Most recent P60
- ☐ Copy of last 3 months salary slips prior to disablement

For **Self Employed Persons** (no requirement if the confirmed income option has been chosen):

- ☐ A copy of your most recent Self Assessment letter and Form 11 Return Summary from the Revenue.
- ☐ A copy of the most recent Audited Accounts (e.g. Company Accounts or Partnership Accounts as appropriate)

1. When do you expect your next business accounts to be finalised?

D D	M M	Y Y Y Y

2. When do you expect to be filing your next self-assessment?

D D	M M	Y Y Y Y

8. Declaration and Agreement

I declare that to the best of my knowledge and belief the information given in this Income Protection Claim Form is true and complete and I have not withheld any material fact.

I fully 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 consent to New Ireland Assurance seeking information in connection with this claim form from any source the Company deems necessary and I authorise the giving of such information.

In the event of a claim, I consent to New Ireland Assurance exchanging medical information and/or reports with my doctor at any time when processing or managing the claim.

I consent to New Ireland Assurance exchanging medical information with my doctor in the event it becomes necessary to do so to enable New Ireland Assurance assess the claim at any time.

I consent to New Ireland Assurance seeking information from any doctor who at any stage has attended me concerning anything which affects my physical or mental health or seeking information from any insurance office to which a claim has been made by me and I authorise the giving of such information.

I understand and consent that New Ireland Assurance 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 it's own behalf and may use or pass the Information to third parties (including, where relevant, private investigators) for matters in connection with the investigation and processing this claim and for administration, regulatory, 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.

I also agree that the Information I provide to New Ireland as part of my claim will be processed by New Ireland to assess and review my claim and cross reference particulars of my claim in insurance industry databases for fraud prevention purposes. I accept that in certain cases, this may involve the sharing of my Information with other insurance providers and private investigators. Guidelines for sharing of Information in this regard are contained in the Code of Practice on Data Protection for the Insurance Sector which has been approved by the Data Protection Commissioner. I understand and accept that New Ireland reserves the right to instruct a private investigator to investigate a claim.

"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 Signed:

D D	M M	Y Y Y Y

New Ireland Assurance Company plc.,

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T: (01) 617 2974 **F:** (01) 617 2050.
E: claim@newireland.ie **W:** www.newireland.ie