PENSIONS
INVESTMENTS
LIFE INSURANCE

Irish Life

HOSPITAL CASH COVER
CLAIM FORM

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 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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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 Hospital or Consultant, signed, dated and stamped.

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.

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

Plan number

Mr ◯ Mrs ◯ Ms ◯

If claim is in respect of a child, enter child's name as claimant.

Name of Claimant

Address

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

Adult ◯ Child ◯

Name and address of usual Medical Attendant/GP

Hospital Details

Name of Hospital

Hospital address

Please provide details of why you were hospitalised

Date of admission d d / m m / y y y y

Date of discharge d d / m m / y y y y

If still in hospital, when do you expect to be discharged?

Payment options

In the event that your claim is approved 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 in part 1 or 2 below.

Please note that if this section is incomplete, we will issue payment by cheque payable to all customers named on the plan.

COMPLETE PART 1 OR PART 2

PART 1: If your plan is in your name and another person's name:

- ○ Pay by cheque payable in 2 names (please note a joint bank account is required in order to cash the cheque)
- ○ Pay by cheque payable in 1 name only (this must be a person named on the plan)
  - Name on cheque:
- ○ Pay by EFT to the bank account you pay your premium from

Both signatures are required:

Please sign and date > Signature 1 ✗ Date d d / m m / y y y y

Please sign and date > Signature 2 ✗ Date d d / m m / y y y y

PART 2: If your plan is in your name only:

- ○ Pay by cheque
- ○ Pay by EFT to the bank account you pay your premium from

Please sign and date > 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.

For children's hospital cash claims, a parent/ policyholder must sign here > Claimant 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 > Claimant Signature ✗ Date d d / m m / y y y y

Section B - to be completed by the treating Hospital or Consultant

Patient's name

Hospital number

1. Describe fully nature of injury/illness

2. On what date were you first consulted on the matter? d d / m m / y y y y

3. How long had the symptoms been present when you were first consulted?

4. To the best of your knowledge has this patient suffered previously from this or a related Illness? Yes ◯ No ◯
   If yes, please give details

5. Date and Time of Admission
   (including time in A&E if admitted through A&E) d d / m m / y y y y am/pm
   Date and Time of Discharge d d / m m / y y y y am/pm
   If still hospitalised, please indicate expected discharge date

6. Comments (if any)

Please sign and date

Doctor's Signature ✗

Date d d / m m / y y y y

Name in Block Capitals

Qualification

Please ensure this form has been stamped by the treating Hospital or Consultant

Hospital Stamp