

Employer Income Protection Claim Form

• Please complete in **BLOCK CAPITALS** and tick (✓) where appropriate

1. Scheme Details

Name of Company:

Scheme Number:

Company Address:

Employer Contact Name:

Telephone: Fax No.:

Email:

2. Claimant Details

Name:

Address:

Date of Birth:

D	D
<input type="text"/>	<input type="text"/>

M	M
<input type="text"/>	<input type="text"/>

Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

 Date joined Company:

D	D
<input type="text"/>	<input type="text"/>

M	M
<input type="text"/>	<input type="text"/>

Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Date First Absent:

D	D
<input type="text"/>	<input type="text"/>

M	M
<input type="text"/>	<input type="text"/>

Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Did claimant make any attempts to resume work since first absence? (please provide details)

3. Occupational Details

Job Title of Claimant:

Annual salary on last day worked: € How many hours per week does this person work?: hours

Please tick the level of physical demand required for this job:

Activity	0-33% of day	33-66% of day	Whole Day	Not Applicable
Standing				
Walking				
Kneeling				
Reaching over head				
Climbing (ladders)				
Climbing (stairs)				
Sitting				
Keyboard				
Lifting (please advise weights involved)				
Pushing/Pulling (please advise weights)				

To what extent could the above physical demands be modified to accommodate a return to work for this claimant?

4. Personal Details

Is the claimant's job available for them to return to?

Yes ☐ No ☐

Can the claimant return to work on a graduated basis?

Yes ☐ No ☐

Is there another position within the company the claimant could return to? If "Yes", please provide details.

Yes ☐ No ☐

Has there been any change in the business environment or in the claimant's role within the company in the past two years? If "Yes", please provide details.

Yes ☐ No ☐

Does the company operate an Occupational Health Programme? If "Yes", please provide details.

Yes ☐ No ☐

Please give details of any discussions that have taken place regarding rehabilitation or return to work.

Are there any other factors that might be relevant to this claim?

(eg Interpersonal difficulties at work, ongoing investigations, complaints, claim against company etc.).

PLEASE ALSO ENCLOSE: Please tick box to confirm that the requested information has been enclosed.

☐

A detailed Job Description

☐

An attendance record for the previous four years

☐

Bank details for Electronic Funds Transfer payment of claim & contact name for payslip

5. Declaration and Agreement

We declare that to the best of our knowledge and belief the information given in this Initial Claim Form is true and complete and we have not withheld any material fact. Material facts are those, which an insurer would regard as likely to influence the assessment and acceptance of a proposal for insurance. If you are in doubt as to whether certain facts are material, such facts should be disclosed.

We consent to New Ireland seeking Information in connection with this claim from any source New Ireland deems necessary and we authorise the giving of such Information.

We 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. We agree that New Ireland or a duly authorised agent of New Ireland may contact us in person, by phone, email or by letter.

We also agree that the Information we provide to New Ireland as part of the claim will be processed by New Ireland to assess and review the claim and cross reference particulars of the claim in insurance industry databases for fraud prevention purposes. We accept that in certain cases, this may involve the sharing of our 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. We 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 given by us or on our 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 Employer:

Position Held:

Date:

D	D	M	M	Y	Y	Y	Y