

# Absence from Work / Accidental Injury - Claim Form

- Please answer the following questions fully to avoid 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. 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](mailto: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

### 1. Claimant details

Name(s):

Address:

  


Date of Birth:

D	D	M	M	Y	Y	Y	Y

Telephone Number:

### 2. Occupational details

What is your current occupation?

Name and address of your current employer:  
(Please state self-employed if this is the case)

  
  


Please provide a description of your normal working duties to include details of any physical work you carry out:

  


What environment do you work? (e.g. office, factory, outdoors etc.)

How many hours per week do you normally work?

On what date did you last undertake any part of your occupation?

D	D	M	M	Y	Y	Y	Y

Please indicate when you estimate that you will be able to carry out any part of your occupation:

D	D	M	M	Y	Y	Y	Y

If you have already returned to work, please advise the date of your return:

D	D	M	M	Y	Y	Y	Y

Have you carried out any work at all (paid or unpaid) since your accident / illness?

☐ Yes ☐ No

If Yes, please advise details to include dates work was carried out.

### 3. Medical details - Please answer the following questions as fully as possible

Please describe your illness or injury:


#### If injury please advise

Date of accident:

D	D	M	M	Y	Y	Y	Y

Date medical advice  
first requested:

D	D	M	M	Y	Y	Y	Y

Circumstances of accident:


#### If illness please advise

Date symptoms first appeared:

D	D	M	M	Y	Y	Y	Y

Date medical advice  
first requested:

D	D	M	M	Y	Y	Y	Y

Have you previously suffered from this injury / illness?

☐ Yes ☐ No

If yes, please give details including dates and doctor/hospitals involved.


Please advise the name and address of the doctor you first attended with this condition:


Name and address of your usual doctor: (If different from above)


Date of last attendance:

D	D	M	M	Y	Y	Y	Y

Date of next attendance:

D	D	M	M	Y	Y	Y	Y

Please give the name and address of any other doctors or specialists you have seen in connection with this condition:


Date of last attendance:

D	D	M	M	Y	Y	Y	Y

Date of next attendance:

D	D	M	M	Y	Y	Y	Y

Are you awaiting any referrals for tests or consultations?

☐ Yes ☐ No

If yes, please advise details.


Does this condition totally prevent you from following all of the duties of your occupation?

☐ Yes ☐ No

If no, please advise details.


## 4. 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.

## 5. Please include the following documents with your claim form

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

☐

### Proof of Income:

**Employed people:** a copy of your three most recent payslips prior to your accident / illness.

**Self-employed:** a copy of your most recent notice of assessment or alternatively, a letter from your Accountant confirming your average weekly earnings over the past year.

☐

**Job Description** - if you have a copy of your job description, please enclose this for our records.

☐

**Section B** - please ensure that your doctor has completed Section B of this form.

## 6. 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 accept that in certain cases, this may involve the sharing of my information with other insurance providers and private investigators. I understand and accept that New Ireland reserves the right to instruct a private investigator to investigate a claim.

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:															
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	Signature of policy owner (If different)*:	Date:															
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\* 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 certified the Life Insured as unfit for work

Patient Name:

Date of birth:

D	D	M	M	Y	Y	Y	Y

What is the nature of this patient's current illness /injury?

Was this condition as a direct result of an accident?

☐

Yes

☐

No

If yes, please advise the circumstances of the accident.

When did your patient first attend you with this illness/injury?

D	D	M	M	Y	Y	Y	Y

Did your patient ever suffer from this or a similar illness /injury?

☐

Yes

☐

No

If yes, please advise details.

Is your patient currently able to work:

☐

On a full-time basis

☐

On a part-time basis

☐

Not at all

If you do not feel this patient is fit to resume work, please advise in detail what factors are currently preventing such a return to work:

What treatment is your patient currently receiving?

When do you expect your patient to be fit to return to work on either a part-time or full-time basis?

D	D	M	M	Y	Y	Y	Y

Please advise the dates you are certifying this patient as unable to work:

From:

D	D	M	M	Y	Y	Y	Y

To:

D	D	M	M	Y	Y	Y	Y

Have you made any referrals for this patient for tests or investigations?

☐

Yes

☐

No

If yes, please advise details.

SIGN  
HERE

Signed:

Position held:

Date

Signed:

D	D	M	M	Y	Y	Y	Y

Practice Stamp

**New Ireland Assurance Company plc.,**

11-12 Dawson Street, Dublin 2.

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

E: [claim@newireland.ie](mailto:claim@newireland.ie) W: [www.newireland.ie](http://www.newireland.ie)

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