GROUP INCOME PROTECTION
EMPLOYER CLAIM FORM

utmost™ CORPORATE SOLUTIONS

HOW WE PROCESS PERSONAL DATA

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 relevant Data Privacy Notice which is always available on our website at: **https://utmostinternational.com/privacy-statements/** (**www.utmostinternational.com**).

HOW TO COMPLETE THIS FORM

If completing by handwriting, please complete this form in full using blue or black ink and BLOCK CAPITALS. If you make a mistake, cross it out, put in the correct details and sign your initials next to the correction. Please do not use correction fluid.

Completed and signed forms, together with supporting documentation, should be scanned and emailed to **claims@utmost.ie** OR Posted to UCS Claims Team, Utmost PanEurope dac, Navan Business Park, Athlumney, Navan, Co Meath C15 CCW8, Ireland.

USING THE EDITABLE FIELDS?

If completing digitally, please ensure your information is saved correctly, we recommend you save the form to your desktop before you start completing the required fields.

EMPLOYER GUIDE TO THE CLAIMS PROCESS

Please refer to our **Group Income Protection Claims Process Map** to guide you through the claims process.

IMPORTANT TO NOTE

If the employee is returning to work before the Deferred Period expires, there is no need to submit a claim form.

If you require further information, please contact your broker in the first instance or Utmost PanEurope on +353 (0)46 909 9760.

Capitalised words and phrases are defined terms as described in the Policy Terms and Conditions.

A EMPLOYER DETAILS

1. Policy number

2. Claim number (if known)

3. Employer name

4. Correspondence address

Postcode | Country

5. Name of individual dealing with claim

6. Telephone number

7. Email address

B BROKER DETAILS

1. Broker name

2. Contact name

3. Telephone number

4. Email address

5. Copy updates to broker[1] ☐ Yes ☐ No

C CLAIMING MEMBER DETAILS

1. Name

2. Title

3. Address

Postcode | Country

4. Home phone number

5. Mobile number

6. Date of birth d d m m y y y y

7. Email address

8. Employee job title

9. Date of joining the company d d m m y y y y

10. Length of time in current position

D CLAIMING MEMBER DISABILITY DETAILS

1. Reason for Disability

2. First date of absence d d m m y y y y

3. Is the Claiming Member seeking legal compensation against a third party, in connection with the declared incapacity? ☐ Yes ☐ No
If Yes, please provide details

[1] Updates will not include medical information.

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4. Has the Claiming Member worked since the date of Disability? ☐ Yes ☐ No

If Yes, please provide details:

DUTIES UNDERTAKEN	DATES	HOURS WORKED	EARNED INCOME
	d d m m y y y y		
	d d m m y y y y		
	d d m m y y y y		
	d d m m y y y y		
	d d m m y y y y		

5. Is the Claiming Member's position still available to them? ☐ Yes ☐ No

6. Could the position be undertaken part-time if the Claiming Member's health prevented them from working full time? ☐ Yes ☐ No

7. Is there an alternative position that could be made available to the Claiming Member? ☐ Yes ☐ No

If Yes, please describe the position

8. How do you keep in contact with the Claiming Member? Please also state frequency of contact

9. Please provide details of all medical or other information you have received regarding the Claiming Member's Disability

10. Describe the Claiming Member's duties and any special skills or qualifications required

11. Is a driving or other type of licence necessary for the Claiming Member to perform their duties? ☐ Yes ☐ No

If Yes, please provide details

12. How many staff directly report to the Claiming Member?

13. How many hours is the Claiming Member contracted to work per week?

14. What is the start and finish time?

15. Have you discussed returning to work with your employee? ☐ Yes ☐ No

If Yes, please provide details

Please list all the duties involved in your employee's insured occupation and the percentage of their working day spent on each:

DUTY	% OF DAY SPENT ON DUTY	DOES THE INCAPACITY PREVENT THEM FROM CARRYING OUT THIS DUTY?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Please provide any additional information that you feel would help us to assess this claim

E FINANCIAL INFORMATION

1. What was the Claiming Member's pre-disability Earnings?

2. What date will salary payment to the employee cease? d d m m y y y y

3. If pension contributions are covered under the policy, please confirm the following:

Type of pension scheme i.e. Defined Benefit, Defined Contribution

How contribution is calculated

Normal Retirement Age under the pension scheme

F EMPLOYER BANK DETAILS

Claim payments will be made to the policyholder.

Employer bank name and address

Postcode | Country

Account name

Account number

Bank sort code - -

BIC

IBAN

Currency of account

How long has the account been held for? Years

Claim payments will be made by Electronic Funds Transfer (EFT).

G EMPLOYER DECLARATION

Please read this carefully

On behalf of the policyholder of this Group Income Protection policy I/we wish to apply for the payment of this claim based on the details in this form and in accordance with the Policy's Terms and Conditions. I understand that any information I provide on the claim that is false or misleading in any material respect and which I either know to be false or misleading or consciously disregard whether it is false or misleading, shall entitle Utmost to refuse to pay a claim and shall entitle Utmost to terminate the coverage under the policy.

By signing this form, I confirm that I have made any other individual whose data may be provided in this form aware that their data will be shared with Utmost PanEurope and that they have read and understood our Privacy Notice.

SIGNATURE

Full name in CAPITAL LETTERS

Position in company

Date d d m m y y y y

INFORMATION NEEDED

To assess a claim, Utmost PanEurope requires evidence from you that the claimant is covered by the policy together with their job description and details of their absence over the last 12 months.

WHAT YOU SHOULD DO

- ☐ Complete and sign the Employers Claim Form.
- ☐ Provide the employee's most recent job description.
- ☐ Provide a copy of absence record for the previous 12 months.
- ☐ Provide three months' payslips.

From the Employee, we need:

- ☐ A completed and signed Employee Claim Form.
- ☐ A certified copy of their Birth Certificate, Driver's Licence or Passport.

RESET

A WORLD *of* DIFFERENCE

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