

GROUP INCOME PROTECTION

EMPLOYEE CLAIM FORM

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. 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.

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.

EMPLOYEE GUIDE TO THE CLAIMS PROCESS

Group Income Protection is designed to provide you with an income if you are unable to work for a long period of time due to illness or accident.

The Group Income Protection policy is effected between your Employer and Utmost PanEurope dac ("Utmost PanEurope dac") and is governed by the policy Terms and Conditions. Your Employer will advise you what benefit is insured under the scheme and, should the claim be admitted, when the benefit will become payable and for what duration.

Group Income Protection policies have a Deferred Period during which time no benefit is payable. During this period you will be subject to the terms of your employer's sick leave policy.

If the claim is admitted the benefit will be paid to your Employer to pay to you via payroll after deduction of relevant tax and social insurance.

Please refer to our video guide to help you to understand this process: [How do I make a claim? - Utmost International](#)

INFORMATION NEEDED

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

We will also require some personal details from you, proof of your age and details of the reasons why you are unable to perform the duties of your job.

The attached claim form and Healthcare Practitioner form should be completed and returned to Utmost PanEurope (see postal address on back cover). On receipt of your these forms, we can assess the information provided and contact your General Practitioner (GP) and/or treating consultant for any additional medical information to support your claim. All medical information is treated as strictly confidential.

You may be contacted by phone (Monday to Saturday only between the hours of 9.00am to 9.00pm, excluding bank holidays or public holidays) unless otherwise agreed with you or visited by appointment at home by an experienced nurse as part of the assessment and rehabilitation process, subject to receiving your informed consent prior to each visit.

WHAT YOU SHOULD DO

- › Complete and sign the Employee Claim Form.
- › Provide a certified copy of your Birth Certificate, Driver's Licence or Passport to verify your identity. Where your married name is different from the name on the identification documentation, we will need a copy of your Marriage Certificate.
- › Send the above to your Employer who will combine it with the information we require from them. Your Employer will return it to us for assessment.

UPDATES AND DECISION

Utmost PanEurope will send updates on the assessment process to your Employer and chase any outstanding medical evidence at regular intervals.

If it is necessary for you to attend an independent medical examination we will agree a mutually convenient time and location.

Once sufficient information has been received to reach a decision on the claim, this decision will be communicated to your Employer who will inform you.

In the event that a claim is declined, Utmost PanEurope will outline the rationale for the decision.

If your Employer is unhappy with the decision they can lodge an appeal against this decision within three months of receiving the decision. Please see the factsheet on the Claims Appeal Process for further information.

BACK TO WORK

Where appropriate to your condition and the duties of your Normal Occupation, we will work with you, your Employer and medical advisers on a 'Back to Work' plan to enable a smooth transition back to work.

A proportionate claim payment may be made while you are on a phased return to work.

If you have a recurrence of the same condition lasting at least one month within six months of the benefit ceasing, we may recommence benefit immediately without waiting for a further Deferred Period.

Claims are subject to periodic reviews and on-going assessment of your ability to perform the duties of your Normal Occupation. Your co-operation with these reviews is part of the policy's conditions.

A CLAIMANT DETAILS

A1 EMPLOYER DETAILS

1. Employer name
2. Policy number
3. Claim number (if known)

A2 PERSONAL DETAILS

1. Name
2. Title
3. Address

Postcode	Country
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4. Home phone number
5. Mobile phone number
6. Date of birth

d	d	m	m	y	y	y	y
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7. Email address
8. What is your height?
9. What is your weight?
10. Are you predominantly Left-handed Right-handed

A3 MEDICAL CONDITION AND ABSENCE

1. First date of absence

d	d	m	m	y	y	y	y
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2. Describe in detail your illness/condition.

3. What work related activities does your current condition prevent you from performing?

4. If you suffered from this illness/condition before, please provide full details including dates, treatment and duration. If you have not suffered from this illness/condition before, please write 'Not Applicable'.

5. Has a diagnosis been made?

Yes No

If "Yes", please provide details.

6. Is your condition

Deteriorating Improving Stable

Please provide details.

7. Are your symptoms

Constant Intermittent

Please provide details.

8. Have you been hospitalised in connection with this illness/condition?

Yes No

If "Yes", please provide details.

9. Are you seeking legal compensation against a third party, in connection with the declared incapacity?

Yes No

If "Yes", please provide details.

10. Have you worked since the date of incapacity?

Yes No

If "Yes", please provide details:

DUTIES UNDERTAKEN	DATES	HOURS WORKED	SALARY PAID
	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		

B MEDICAL INFORMATION

1. What treatment are you receiving?

2. If medication has been prescribed, please list the name(s) of the medication and the prescribed dosage.

3. Name and address of your GP

Postcode
Country

Contact number

4. Name and address of any other doctors/specialists/consultants you attended for this condition.

Postcode	Country

Contact number

Postcode	Country

Contact number

C OCCUPATION

1. What is your current job title?

2. How long have you been doing your current job?

3. Describe your duties and any special skills or qualifications required.

4. Is a driving or other type of licence necessary for you to perform your duties?

Yes No

If "Yes", please provide details.

5. How many staff directly report to you?

6. How many hours are you contracted to work per week?

7. How many hours did you work on average per week?

8. Please provide a list of all duties involved in your job and the percentage of your working day you spent on each.

DUTY	% OF DAY SPENT ON DUTY	DOES THE INCAPACITY PREVENT YOU FROM CARRYING OUT THIS DUTY? YES/NO	
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No
		Yes	No

9. Please indicate the percentage of your day spent doing the following.

ACTIVITY	% OF DAY SPENT ON ACTIVITY	DOES THE INCAPACITY PREVENT YOU FROM CARRYING OUT THIS DUTY? YES/NO	
a. Climbing ladders or similar		Yes	No
b. Carrying or lifting heavy items		Yes	No
c. Standing		Yes	No
d. Crawling or kneeling		Yes	No
e. Sitting/driving		Yes	No
f. Walking		Yes	No
g. Bending		Yes	No
h. Reaching with your arms		Yes	No
i. Other, please specify		Yes	No

10. How often are you in contact with your Employer?

11. Has your Employer discussed returning to work with you?

Yes No

12. If "Yes", please provide details.

13. Would you be interested in our Rehabilitation Service which may assist you to return to work?

Yes No

If "No", please provide details.

D FINANCIAL INFORMATION

1. What was your pre-disability salary?
2. Do you receive a regular performance appraisal? Yes No
3. When was your last performance appraisal?

d	d	m	m	y	y	y	y
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4. Current income

DUTY	AMOUNT	FREQUENCY	SOURCE - NAME AND ADDRESS
Amount of Social Insurance/State Benefit (if any)			
Other Pension/ Salary amounts			
Other Sickness and Accident policies			
Other Income from any source			

5. Please provide full details of any personal sickness and accident policies.

INSURER	POLICY NUMBER	BENEFIT INSURED	BENEFIT PAYABLE

E ADDITIONAL INFORMATION

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

F DATA PRIVACY

Utmost PanEurope dac recognises that protecting your personal information, including special categories of data (sometimes referred to as sensitive personal data), is very important to you and that you have an interest in how we collect, use, store and share such information. We have produced a privacy notice which clarifies these details and explains your rights in relation to your personal data and how to action these rights with us, including your right to make a complaint. The privacy notice is available on our website utmostinternational.com/privacy-statements/

The General Data Protection Regulation ('GDPR') came into force across Europe on the 25th May 2018. GDPR aims to give European citizens more control over their data and to create a uniformity of rules to enforce across Europe.

We reserve the right to change the privacy notice from time to time at our sole discretion. We encourage you to periodically review the privacy notice to keep informed about how we use your personal data and how we keep it protected.

Utmost PanEurope dac need to collect, process, share and store your personal data to fulfil its contractual obligations under the policy to handle your claim. For this to happen we require your explicit consent, if you do not give your consent unfortunately Utmost will not be able to handle or process your claim.

F1 ACCESS TO MEDICAL RECORDS

- › We request your explicit consent to allow us to approach any doctor for medical information about anything which affects your physical or mental health.
- › We may ask you to contact your doctor to speed up the completion of reports that we have requested.
- › If we ask you to attend a medical examination, it will be necessary to share the application information with an authorised third party and we will arrange for the examination to take place.
- › It may be necessary to share medical information obtained from a medical examination report or from a health screening report with your doctor.
- › On occasions, the electronic transmission of medical reports may help speed up the assessment of your application. We only accept electronic transmissions directly to a secure location to ensure confidentiality.
- › We have a Confidentiality Policy in place to ensure medical information is held securely and access is limited.
- › All answers to questions in this form, and any questions we subsequently ask, must be correct.
- › By ticking the box **I explicitly consent** that Utmost may approach any doctor for medical information about anything which affects my physical or mental health

SIGNATURE

Date

d	d	m	m	y	y	y	y
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Full name in
Capital Letters

G PERSONAL DECLARATION

- › I declare that, as a result of illness or injury, I wish to claim benefit under the above Policy.
- › I declare that I have been unable to perform the substantial duties of my occupation due to illness or injury since the first date of absence detailed.
- › I understand that any information on the claim provided by me 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 the claim and shall entitle Utmost to terminate my coverage under the policy.
- › I understand that Utmost PanEurope can use my personal information for any of my subsequent claims to Utmost PanEurope.

- › I undertake to inform Utmost PanEurope immediately, in writing, if I carry out any work whatsoever and I understand that failure to do so may entitle Utmost PanEurope to cancel benefits under this Policy.
- › I undertake to inform Utmost PanEurope of any changes in my health or employment whilst I am a claimant.
- › I understand that an authorised representative of Utmost PanEurope and/or any third party appointed by them may visit or telephone me to discuss matters pertaining to the claim and that prior authorisation will be obtained from me prior to any visit.

By ticking the box **I explicitly consent** to the collection, processing, sharing and storing of my personal data inclusive of any sensitive data by Utmost PanEurope dac.

By ticking the box **I DO NOT consent** to the collection, processing, sharing or storing of my personal data inclusive of any sensitive data by Utmost PanEurope dac.

SIGNATURE

Date

d	d	m	m	y	y	y	y
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Full name in
Capital Letters

H CONSENT TO OBTAIN INFORMATION

I hereby explicitly consent to Utmost PanEurope dac and/or a third party appointed by Utmost:

- › Being provided with medical information/reports from any doctor, specialist, clinic or hospital who has treated me in relation to my physical or mental health.
- › To the Medical personnel of the Occupational Health Department of my Employer to correspond, release or obtain Occupational Health reports or any relevant medical information to or from the Chief Medical Officer (CMO) of Utmost PanEurope.
- › To sending and receiving information from any other insurance office, revenue or benefit office or Employer.
- › I agree that a copy of this authorisation shall have the validity of the original and that the authorisation shall be valid for the duration of the claim.

By ticking the box **I explicitly consent** that Utmost PanEurope can if required obtain the above information.

SIGNATURE

Date

d	d	m	m	y	y	y	y
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Full name in
Capital Letters

A WORLD *of* DIFFERENCE