GROUP INCOME PROTECTION

HEALTHCARE PRACTITIONER FORM

utmost™ CORPORATE SOLUTIONS

USING THE EDITABLE FIELDS?

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

WHAT IS INCOME PROTECTION?

Income Protection is designed to help an employer to provide an employee with some replacement income when they are unable to work for a long period of time due to illness or accident.

The Group Income Protection Cover policy is effected between the employer and Utmost PanEurope dac ("Utmost PanEurope") and is governed by the policy Terms and Conditions.

MEDICAL EVIDENCE AND CONSENT

To assess a claim, Utmost PanEurope requires evidence from the employer that the employee is covered by the policy and details of their job.

From the employee, we will need some personal details and medical evidence to support their absence from work and their inability to perform the job.

Evidence supplied by the employee supports the employer's claim on the policy. Utmost PanEurope has obtained the explicit consent from the employee (see attached) to request ongoing detailed medical information from their doctor and/or specialist consultants. All medical information is treated as strictly confidential.

A copy of this consent is attached.

REQUIREMENTS

As a Healthcare Practitioner nominated by the employee, please complete and sign the attached Practitioner Report. The report is essential to ascertain the clinical diagnosis for the employee claiming benefit and understand how it significantly interferes with their ability to work. Early completion and return of this report will ensure prompt processing of the employee's claim.

Please send the completed form to:

Chief Medical Officer – Utmost Corporate Solutions Department
Utmost PanEurope dac, Navan Business Park, Athlumney, Navan C15 CCW8, Co. Meath, Ireland

Utmost PanEurope will meet reasonable costs for the completion of this report. Utmost PanEurope can be contacted by:

T +353 (0)46 909 9760 F +353 (0)46 909 9848 E **claims@utmost.ie**

A CLAIMANT (PATIENT) DETAILS

1. Name

2. Date of birth d d m m y y y y

3. Address

Postcode Country

4. Occupation

5. Employer

PART 1 PATIENT HISTORY

1. When did you become the patient's doctor?

d d m m y y y y

2. Do you hold full Medical Records from this date?

☐ Yes ☐ No

If "No", please confirm the date your records begin.

d d m m y y y y

3. When did the claimant first consult you in relation to this incapacity?

d d m m y y y y

4. Is the claimant still consulting you regarding this condition?

☐ Yes ☐ No

5. When did you last see the claimant in relation to this incapacity?

d d m m y y y y

PART 2 INFORMATION ON DISABILITY

1. When was the claimant first absent?

d d m m y y y y

2. What is the exact nature and cause of disability?

3. Describe the symptoms which prevent the claimant from working.

4. Confirm the result of all investigations carried out (please provide copies of all relevant hospital reports and test results).

5. Please provide details of any planned investigations or surgery.

PART 3 CLAIMANT RESTRICTIONS

Is the claimant, as a result of their condition, restricted in any of the following:

	YES	NO	DETAILS
a. Sitting	☐	☐	
b. Walking	☐	☐	
c. Standing	☐	☐	
d. Bending	☐	☐	
e. Climbing (i.e. ladders/stairs)	☐	☐	
f. Lifting weights	☐	☐	
g. Driving	☐	☐	
h. Maintaining concentration	☐	☐	

PART 4 TREATMENTS

1. Please provide details of current treatment plan including name and dosage for any medication.

2. Please provide details of types and effect of previous treatment plans.

3. Are there any side effects as a result of the medication that may interfere with the claimant's ability to work?

PART 5 PROGNOSIS

1. Is the claimant's condition:

a. Improving ☐ Yes ☐ No

b. Deteriorating ☐ Yes ☐ No

c. Static ☐ Yes ☐ No

If the condition is not improving, please confirm why?

2. What is your prognosis for the claimant?

PART 6 EXTENT OF DISABILITY

1. Is the claimant in your opinion currently able to carry out all of the duties of their normal occupation?

☐ Yes ☐ No

If "Yes", confirm the date the claimant was fit to do so.

d	d	m	m	y	y	y	y

If "No", how long is the expected duration of absence as a result of this disability?

☐ 0-3 months ☐ 3-6 months ☐ 6-12 months ☐ 1-3 years ☐ 3+ years

If "No", please confirm the normal duties of the claimant's occupation that they are currently unable to perform.

2. Is the claimant currently able to resume their normal occupation on a part time basis?

☐ Yes ☐ No

If "Yes", please confirm the duties of their normal occupation the claimant is currently able to perform.

If "Yes", please outline the nature of work, the frequency and the number of hours each day.

3. When is the claimant likely to be able to resume full time work?

PART 7 REHABILITATION

1. Do you feel it would be in the claimant's interest to resume work as soon as possible?

☐ Yes ☐ No

If "No", please explain.

2. Have you discussed returning to work with the claimant?

☐ Yes ☐ No

If "Yes", please provide details.

If "No", please provide an approximate date when these discussions are likely to occur.

If it would be possible for the claimant to return to work part time or return to an alternative occupation, please give details of what rehabilitation steps that can be put in place to achieve this.

Additional Comments

Please provide any additional comments which may be of assistance in our assessment.

PART 8 OTHER PRACTITIONER(S)

NAME AND ADDRESS OF PRACTITIONER	SPECIALITY	DATE FIRST ATTENDED	DATE LAST ATTENDED	DATE OF NEXT APPOINTMENT
		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	d d m m y y y y

B PRACTIONER(S) DECLARATION

In order for us to process this claims review promptly and efficiently, please forward copies of any case notes, hospital or specialist reports you may hold.

Practice name

Address

Postcode | Country

Qualification

SIGNATURE

Date d d m m y y y y

Full name in Capital Letters

Practitioner's stamp

RESET

A WORLD *of* DIFFERENCE