

# GROUP INCOME PROTECTION

## HEALTHCARE PRACTITIONER FORM

### 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.

### 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.

### WHAT IS INCOME PROTECTION?

Income Protection is designed to provide some replacement income when an employee is unable to work due to illness or injury.

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 patient is covered by the policy and details of their job.

From the patient<sup>1</sup>, 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 patient supports the employer's claim on the policy. Utmost PanEurope has obtained the explicit consent from the patient (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 patient, please complete and sign the attached Practitioner Report. The report is essential to ascertain the clinical diagnosis for the patient 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 patient'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](mailto:claims@utmost.ie)

### A PATIENT DETAILS

1. Name	<input type="text"/>									
2. Date of birth	d	d	m	m	y	y	y	y		
3. Address	<input type="text"/>									
	<input type="text"/>									
	Postcode					Country				

<sup>1</sup> Patient refers to the Claimant.

4. Occupation

5. Employer

## A1 PATIENT HISTORY

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

2. Do you hold full Medical Records from this date?  
Yes No  
If "No", please confirm the date your records begin.

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

4. Is the patient still consulting you regarding this condition? Yes No

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

## A2 INFORMATION ON DISABILITY

1. When was the patient first absent?

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

3. Describe the symptoms which prevent the patient 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.

### A3 PATIENT RESTRICTIONS

Is the patient, 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			

### A4 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 patient's ability to work?

### A5 PROGNOSIS

1. Is the patient'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 patient?

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A6 EXTENT OF DISABILITY

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

Yes                  No

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

d	d	m	m	y	y	y	y
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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 patient's occupation that they are currently unable to perform.

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2. Is the patient 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 patient is currently able to perform.

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

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

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A7 REHABILITATION

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

Yes No

If "No", please explain.

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

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 patient 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.

A8 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** PRACTITIONER(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
Practitioner Name		
Qualification		

**SIGNATURE**

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Date

d	d	m	m	y	y	y	y
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Practitioner's stamp

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A WORLD *of* DIFFERENCE

[www.utmostinternational.com](http://www.utmostinternational.com)

Utmost Corporate Solutions is a trading name used by Utmost PanEurope dac and Utmost Worldwide Limited.

Utmost PanEurope is regulated by the Central Bank of Ireland.

Utmost PanEurope dac is a designated activity company registered in Ireland (number 311420), with a registered office at Navan Business Park, Athlumney, Navan, Co. Meath, Ireland C15 CCW8.

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