GLOBAL RISK SOLUTION GROUP INCOME PROTECTION

HEALTHCARE PRACTITIONER REPORT

utmost™ CORPORATE SOLUTIONS

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.

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 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 and (or) Utmost Worldwide Limited and is governed by the policy Terms and Conditions.

MEDICAL EVIDENCE AND CONSENT

To assess a claim, Utmost PanEurope dac and (or) Utmost Worldwide Limited requires evidence from the employer that the patient[1] is covered by the policy and details of their job.

From the patient, 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 dac and (or) Utmost Worldwide Limited 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.

REQUIREMENTS

As a Healthcare Practitioner nominated by the patient, please complete and sign this Practitioner Report. The report is essential to ascertain the clinical diagnosis for the patient claiming benefit and understand how their condition 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 scanned report to: **claims@utmost.ie** for Utmost PanEurope claims or **underwritingandclaims@utmostworldwide.com** for Utmost Worldwide claims.

OR Posted to

Ireland (for Utmost PanEurope claims)

UCS Claims Team,
Utmost PanEurope,
Navan Business Park,
Athlumney,
Navan,
Co Meath,
C15 CCW8,
Ireland.

or

Guernsey (for Utmost Worldwide claims)

UCS Claims Team,
Utmost Worldwide Limited,
Utmost House,
Le Truchot,
St. Peter Port,
Guernsey,
GY1 1GR.

[1] Patient refers to the Claimant.

A PATIENT DETAILS

1. Name

2. Date of birth — d d m m y y y y

3. Address

Postcode | Country

4. Occupation

5. Employer

A1 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 patient first consult you in relation to this incapacity? — d d m m y y y y

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? — d d m m y y y y

A2 INFORMATION ON DISABILITY

1. When was the patient 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 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 RESTRICTIONS

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

	YES	NO	TREATMENT PRESCRIBED
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?

A6 EXTENT OF DISABILITY

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

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.

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.

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

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

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 or job modifications 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 PRATITIONER	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

Email address

Practitioner Name

Qualification

SIGNATURE

Date d d m m y y y y

Practitioner's stamp

RESET

A WORLD *of* DIFFERENCE