

PERMANENT HEALTH INSURANCE CLAIM FORM

(To be completed by the Life Assured)

STEP 1 – LIFE ASSURED DETAILS				
Title (Please tick)	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Mr	<input type="checkbox"/> Other (in full)
Surname	<input type="text"/>		Forename(s) (in full)	<input type="text"/>
Present Address	<input type="text"/>			
Date of Birth (mm/dd/yyyy)	<input type="text"/>	<input type="text"/>	<input type="text"/>	Policy Number <input type="text"/>
Occupation	<input type="text"/>			
1(a). Please advise name and address of your usual doctor: (if you have changed doctor in the last 3 years please provide details of previous GP)				
<input type="text"/>				
1(b). Please advise name and address of the doctor who treated you for the condition below, if not your usual doctor:				
<input type="text"/>				
2. Please provide as much detail as possible regarding the nature and extent of your disability, including details of any diagnosis made for the cause of your disability				
<input type="text"/>				
3 (a). Please advise date of onset of symptoms of the condition causing your disability:				
<input type="text"/>				
3 (b). Please advise nature and date of any investigations or surgery you have undergone:				
<input type="text"/>				
4. Please note any further comments which you feel may assist Phoenix Ireland in dealing with your claim.				
<input type="text"/>				
STEP 3 – DECLARATION				
I declare that the answers given in this claim form are to the best of my knowledge and belief true and complete.				
I declare that the above statements are accurate. I hereby consent to Phoenix Ireland seeking information in connection with this claim from any Doctor who has at any time attended me or from any other person and I authorise the giving of such information.				
Signature of Life Assured	<input type="text"/>	Date	<input type="text"/>	