ZURICH

Hospital Cash Benefit

LIFE INSURED

POLICY NUMBER

1. Please state the exact nature of the illness/disease/injury for which you are/were hospitalised.

Please confirm the date that you first attended a doctor for this condition.

2. What were your symptoms?

What date did they first start?

3. Please give details of all surgery/treatment/procedures undertaken.

4. Have you previously suffered from this or any related condition? ◯ Yes ◯ No

If yes, please give details.

Continued overleaf

5. What is the name and address of your usual doctor?

Name:

Address:

6. Please specify the exact time and date of admission and discharge.

Admission: Time ☐☐:☐☐ Date ☐☐☐☐☐☐☐☐

Discharge: Time ☐☐:☐☐ Date ☐☐☐☐☐☐☐☐

7. Please give the name and address of the hospital and the name of the doctor(s) attended there.

Hospital:

Doctor(s) attended:

DECLARATION

I declare that the above statements are true and complete and that I am the person referred to in the particulars given. In order to process this claim, I acknowledge that it may be necessary for Zurich Life Assurance plc ('Zurich Life') to seek information from any doctor who has attended me or subsequently attends me, or any hospital in which I have received or subsequently receive treatment, and I authorise the giving of such information. I also authorise the release, to Zurich Life, of any other information, which Zurich Life considers relevant to enable my claim to be dealt with.

For the purpose of data protection legislation Zurich Life is the data controller. Information on how Zurich Life collects, stores, and processes data can be obtained in its Privacy Policy which is available at www.zurich.ie/privacy-policy.

By signing this form I confirm that I have read and understand the Privacy Policy.

Name:
(Please Print)

Signature:
X

Date:

Please sign and date.

Continued overleaf

ZURICH

Certificate of Hospitalisation

LIFE INSURED	
POLICY NUMBER	

1. Please state the exact diagnosis of the condition for which the patient attended hospital.

2. Was there any underlying illness? If so, please give details including any previous history.

3. Please detail all surgery/treatment/procedures undertaken.

4. What was the date of the first consultation for this condition?

5. Please advise the name and address of the referring doctor.

Name:

Address:

6. Was the stay in hospital for the purpose of cosmetic or elective surgery? ◯ Yes ◯ No

If yes, please give details

Continued overleaf

7. Please specify the exact time and date of admission and discharge.

Admission: Time ☐☐:☐☐ Date ☐☐☐☐☐☐☐☐

Discharge: Time ☐☐:☐☐ Date ☐☐☐☐☐☐☐☐

Please sign and date.

Signature:
X

Date: ☐☐☐☐☐☐☐☐

Hospital stamp:

Zurich Life Assurance plc
Zurich House, Frascati Road, Blackrock, Co. Dublin, Ireland.
Telephone: 01 283 1301 Fax: 01 283 1578 Website: www.zurich.ie

GR: 2515 Print Ref: ZL LP 268 0518

ZURICH®