KEANEY INSURANCE BROKERS LTD.

Please complete and sign the Form and forward along with the requested documentation to; Keaney Insurance Brokers Ltd, 30 Lower Leeson Street, Dublin 2,

PERSONAL ACCIDENT/ILLNESS BENEFIT

CLAIM FORM

Full Name: (as known to the employer) (Mr/Mrs/Miss/Ms) _____

Alternative name: (if also known by any other version of name) _____

Home Address: _____

_____

_____

_____

Telephone Number: _____

Mobile Number: _____

Email Address: _____

Date of Birth: _____

Employer Name: _____

Workplace Address _____

_____

_____

Staff/Payroll Number (please leave blank if unknown) _____

Grade/Job Category: _____

Approximate date of joining FORSA: _____

If you were a member of a union prior to 2nd January 2018, please confirm which union:

IMPACT ☐

CPSU ☐

PSEU ☐

KEANEY INSURANCE BROKERS LTD.

1. **Please describe your injury/condition in full (continue on a separate sheet if required):**

2. **On what date did your injury or condition first occur or did you first note symptoms?**

3. **On what date was your injury or condition diagnosed?**

4. **Please provide full details including dates of any tests/investigations which have been carried out (please provide name, department, reference (if appropriate) and address of the institution where such tests were performed (continue on a separate sheet if required):**

5. What treatment are you currently receiving?

6. Have you previously suffered from the same or any similar injury or condition? Please provide full details including dates:

7. When did you first consult your General Practitioner for this injury or condition?

8. Please provide the name and address of your General Practitioner?

Name:

Address:

Email Address:

Telephone Number:

9. Please provide the name and address of the doctor(s)/specialist(s) consulted for this condition, or details of hospitalisation. Please indicate who would be the most appropriate to contact:

Name:

Address:

Email Address:

10. **Please provide any further details you feel may help us when assessing your claim:**

_____

_____

_____

_____

11. **Have you previously made a claim under the FORSA Critical Illness Policy? If yes, please confirm the date and reason for the claim,**

YES	NO

***delete as applicable**

_____

_____

_____

_____

12. **From what date were you totally disabled from attending your usual occupation?**

_____

13. **Is your disability permanent and irreversible and such that you are unable to perform any gainful employment?**

YES*	NO*

***delete as applicable**

14. **Is your disablement solely due to the stated injury/condition?**

YES*	NO*

***delete as applicable**

If no please give details:

_____

_____

_____

Access to Medical Reports Act 1988

Your rights under this Act – please read this carefully

a) You do not have to agree to a medical report

b) You can see the report before your doctor sends it to us, or during the six months after that.

c) You can ask the doctor to change any of the report if you think it is wrong or misleading. If the doctor does not agree, you can write your comments on a sheet of paper and attach them to the report.

d) If you ask your doctor for a copy of the report, you might have to pay for it. The doctor does not have to show you parts of the report which:

- **Might damage your, or anyone else's physical or mental health.**
- **Would give away the doctors intentions for treating you; or**
- **Would tell you about someone who has given information about you. (This does not apply if that person agrees to you knowing or is a health worker looking after you).**

The doctor must tell you if he or she has not shown you part of the report. If the whole of the report is affected, your doctor must not send it to us unless you agree.

If you tell us you want to see the reports before your doctor sends them to us, your doctor must show them to you first unless you fail to arrange to see them within 21 days.

Please tick one box

I wish to see reports before they are sent to the Company. ☐

I do not wish to see reports before they are sent to the Company. ☐

Declaration

I hereby certify that the foregoing information is true and correct and I agree that any statement made by me and found to be false shall surrender all my rights under my policy at the option of Underwriters. I understand that Sedgwick will verify my membership details with Fórsa
I hereby authorise any hospital, physician, employer or any other person to furnish all information as requested by Sedgwick or its representative in consideration of the claim.
Copies of this declaration will be legally valid.
I understand that this form will be passed to or used by member companies of Sedgwick and Underwriters for the purpose of my insurance. This includes underwriting, processing, claims handling, membership verification by Fórsa and fraud prevention, which could include passing details to agents of Sedgwick or other insurers. You may ask other insurers for information to check the information I have given

Sedgwick's "caring counts"® commitment is to value the right of privacy of the companies and individuals we serve. It is Sedgwick's policy to comply with all applicable privacy and data protection laws and maintain the trust of those we serve.
We want to share with you our policy to what personal information we may collect, how we may use this information and other important areas relating to your privacy and data protection. Please find below links to the policies that apply to all internet sites and applications of Sedgwick and its groups of companies.
Introduction and scope
Sedgwick, its subsidiaries and affinities ("Sedgwick," "we," "us," "our,") take your privacy seriously.
This Privacy Notice describes the types of Personal Data that we obtain through the Sites and Services (each as defined below), how we may use that Personal Data, with whom we may share it, and how you may exercise your rights regarding our processing. The Notice describes the measures we take to safeguard the Personal Data that we obtain and how you can contact us about our privacy practices. We conclude by describing further specific rights that may be available in your jurisdiction.
"Personal Data" is information that identifies you or other individuals (such as your dependents). This Privacy Notice describes how we will handle Personal Data that we collect through:
Our websites and other software applications made available through computers and mobile devices (the "Sites") and
Claims handling, loss adjusting, or similar processes such as claim forms, telephone calls, e-mails and other communications with us, as well as from claim investigators, medical professionals, witnesses or other third parties involved in our business dealings with you (the "Services").

Contact
If you have questions about this Privacy Notice or about Sedgwick's privacy practices, please contact our privacy team via e-mail at privacyissues@sedgwick.com or by post at 8125 Sedgwick Way, Memphis, TN 38125
By signing this form, I confirm that I have read and understand the Privacy Policy.

Claimants Signature:

Full Name:

Full Address:

Email Address:

Date:

Data Protection Act 1998

I understand and consent to the use of any information provided by me for the operation of this insurance. This includes the process of underwriting, administration, claims management, rehabilitation and handling customer concerns.

I understand that in order to do this the information may be shared with other insurers, re-insurers, insurance intermediaries and service providers who are involved in either the operation of insurance, which covers members or the member's benefits arrangements provided by the company.

I understand the data will be processed fairly and securely in accordance with the Data Protection Act 1998 and the details will be stored on computer, but will not be kept for longer than necessary.

I confirm that the data in relation to this insurance has been obtained and passed to Sedgwick in accordance with the requirements of the Data Protection Act 1998.

Members Declaration

I hereby apply to Sedgwick for payment of the Permanent Total Disability amount claimed. I declare that I am a Member of the Scheme and paying premiums up to the date of diagnosis and the particulars provided are correct to my knowledge and belief. I confirm that payment of this claim will discharge all liability under this Contract for the illness upon which the claim was settled and such related illnesses decided on by the Company.

TO BE COMPLETED BY THE MEMBER

Permanent Total Disability amount being claimed : EURO 5,000

Estimated Date of joining theScheme: / / (dd/mm/yyyy)

Authorised Signature:

Print Name:

Date: / / (dd/mm/yyyy)

Settlement of this claim will be made by electronic transfer

Member's Bank Details:	
Bank Name:	
Bank Address:	
Name on Account:	
Bank Sort Code:	
Bank Account Number:	
IBAN:	