

FÓRSA CRITICAL ILLNESS AND PERSONAL ACCIDENT CLAIM FORM

Please complete and sign this form on pages 8 and 9 and return it either by post or email to:

Gallagher,
15 Parkgate Street,
Dublin,
D08 W866

Or

forsaclaims@ajg.ie

Upon receipt of your completed claim form, Gallagher will check with Fórsa that you are eligible to make a claim. If you are eligible, Gallagher will then pass your completed claim form to Sedgwick Dublin who will assess and process your claim.

If you would like further information on how Gallagher use your personal information, please read our privacy notice which can be found on the Gallagher Ireland website. If you are unable to view our privacy notice online, please call or write to us and we will send a copy in the post.

For any queries please contact:

Martin Hudson

Martin_hudson@ajg.com

Tel: +353 1 882 0854

Mob: +353 87 165 7560

Before completing this form please read the 'Information for Members Document' available on the Fórsa website here: [Information for Members Document](#). This sets out what is covered under your policy and what is not covered and the definition of the illnesses below. In order to submit a claim for our review, your injury or condition needs to fall within the definition of one of the illnesses below.

List of illnesses	Please tick which illness you are claiming for
Cancer	<input type="checkbox"/>
Coronary artery bypass grafts	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>
Kidney failure	<input type="checkbox"/>
Major organ transplant	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
Loss of limb	<input type="checkbox"/>
Blindness	<input type="checkbox"/>
Or Permanent Total Disablement	<input type="checkbox"/>

1. Full name (as you are known to your employer, including any alternative names used)

2. Date of Birth

3. Email address

4. Home address

5. Telephone number that you would like to be contacted on (should we need to speak to you)

6. Employer name and address

7. On what date did you first notice your injury or symptoms for your condition and when did you first consult your General Practitioner (GP)?

12. Have you previously suffered from the same or any similar injury or condition? Provide full details including dates

13. Provide the name, address and email address of your General Practitioner (GP)

Consent to obtain medical report

Sedgwick in Dublin will be the claims handler for your claim.

To assess your claim Sedgwick may need to request a medical report from your medical practitioner(s) on your condition/injury. Sedgwick can only obtain a medical report with your consent. You do not have to give your consent but your claim might be denied if Sedgwick do not receive medical documents evidencing your injury/condition.

You can request to see the report before your doctor sends it to Sedgwick. If you wish to view the report the doctor will hold it for 21 days please arrange to see the report during that time so that the report can be sent to Sedgwick as quickly as possible. If you request a copy of the report, your medical practitioner can charge you a reasonable fee.

Please tick one box:

I consent to Sedgwick making an application for a medical report and **I wish to see the report before it is sent to Sedgwick.**

I consent to Sedgwick making an application for a medical report and **I do not wish to see the report before it is sent to Sedgwick.**

Copies of this declaration will be legally valid.

Name

Signed

Dated

Address

Member's Declaration

I request Sedgwick consider my claim for payment of Euro 5,000 in respect of the benefit under the Fórsa critical illness and personal accident insurance policy.

I confirm I am a member of Fórsa and have paid my membership fees in full up to the date of diagnosis of my condition/date of injury to which this claim relates. I understand that Gallagher will verify my membership details with Fórsa.

I believe the information I have provided is true and correct. I understand that if any of the information I have provided in relation to my claim is found to be false, this may result in my claim being denied.

Should this claim be agreed, I confirm that payment of this claim will constitute full and final settlement of any liability under the Fórsa critical illness and personal accident insurance policy in respect of the injury/condition described above.

Full Name

Signature

Date

Address
