

Firefighter PA Claim Form

FF PA 11 2019



Important note: Please make sure that the information you give is as clear and complete as possible. Please complete in BLOCK CAPITALS or online, save and print.

Claim No:

SECTION 1: GENERAL DETAILS

1. Policyholder Details

Policyholder Name: Policy No:

Address:

Contact Number:

2. Claimant Details

Name:

Address:

Contact Number:

Email Address:

Date of Birth: Retained Firefighter Full-Time Firefighter

If 'Retained' are you employed elsewhere? Yes No

If 'Yes', please provide details:

Name of Attending Doctor:

Is this your usual medical attendant? Yes No

If 'No', please provide details of your usual medical attendant:

Do you have a Private Health Insurance Policy? Yes No

If 'Yes,' please provide scheme/plan name and provider:

Policy Scheme/Plan:

Do you have other Personal Accident Policies with any other Insurer? Yes No

If 'Yes', please provide full company name:

Please complete to allow benefit payments to be made via EFT

Name on Bank Account:
Beneficiary or Client Account:

Name of Branch:

IBAN:

3. Accident Details

Location:

Date:

Time:

Please describe exactly what happened:

What injuries have you sustained?

Have you previously suffered from similar injuries? Yes No

If 'Yes', please give details:

Name(s) and
Address(es)
of any witness(es):

SECTION 2: DISABILITY BENEFIT

Notes for Claimants: Any fee for a medical certificate is payable by the claimant. Further medical certificates are required at regular intervals during periods of disablement. Interim payments of benefits are normally made on request subject to satisfactory medical evidence.

The claimant may be required to submit to medical examination on behalf of and at the expense of IPB Insurance in connection with any claim.

To be used as a Supplementary Certificate:

1. Medical Certificate (to be completed by Firefighter)

In relation to your alternative employment (Retained Firefighter only), please describe in as much detail as possible, your day-to-day duties:

What injuries have you sustained?

Have you previously suffered from similar injuries?

Yes No

If 'Yes', please give details:

Declaration

I/We hereby declare that the statements on this form and the information provided in addition are true and complete, to the best of my/our knowledge and belief.

Signature:

Date:

2. Medical Certificate (To be completed by Doctor)

This is to certify that:

Sustained the following injuries:

And is unable to attend firefighting duties and, if applicable, all duties noted above: from to

And can only attend to some firefighting duties (full-time only): from to

And is unable to attend all firefighting duties but can attend to the majority of duties noted above: from to

Date of last attendance:

Is surgical intervention necessary or likely? Yes No

On the basis of your existing knowledge and without undertaking any further examinations, is it your opinion that the disablement indicated above is solely attributable to the specified injury sustained? Yes No

If not, please state below any contributing factors and the extent to which disablement is or has been thereby affected:

Signature: Qualification:

Print Name:

SECTION 3: MEDICAL EXPENSES

Receipts/Invoices must be provided in support of a claim for Medical Expenses

Please provide a breakdown of medical expenses sought:

Services of a doctor or consultant: €

Diagnostic procedures (X-Ray, etc): €

Physiotherapy or similar treatment: €

Expenses incurred on any medical, surgical or nursing appliance: €

Prescriptions: €

In-patient treatment: €

Other Expenses (Provide brief details below): €

€

Total: €

Declaration

I/We hereby declare that the statements on this form and the information provided in addition are true and complete, to the best of my/our knowledge and belief.

Signature:

Date:

Data protection notice

IPB Insurance (IPB) is committed to protecting your personal information. IPB is a data controller and is required to comply with the Data Protection Acts 1988 - 2018 and the General Data Protection Regulation. The information that you provide ('data') will be used for the administration of your policy and/or any claims made on the policy. Data is at all times treated as confidential and the appropriate measures are taken to ensure it is secure. A copy of our Data Protection Notice can be found on our website www.ipb.ie. The notice explains why we collect and use your data, who we share your data with, your data protection rights, how long we retain your data for, where your data is located and what to do if you have any data protection complaints. If you would like to receive a copy of the Data Protection Notice you can email dpo@ipb.ie or write to Data Protection Officer, IPB Insurance, 1 Grand Canal Square, Grand Canal Harbour, Dublin D02 P820.

Please return completed form to:

The Claims Department

IPB Insurance, 1 Grand Canal Square, Grand Canal Harbour, Dublin D02 P820, Ireland.

Tel: +353 1 639 5500 Fax: +353 1 639 5540 Email: claims@ipb.ie Web: www.ipb.ie

Reg. No. 7532 Republic of Ireland.

IPB Insurance CLG, trading as IPB Insurance, is regulated by the Central Bank of Ireland.

For business in the UK, IPB Insurance is authorised by the Central Bank of Ireland and subject to limited regulation by the Financial Conduct Authority.

