Income Protection Claims

Medical Certificate

Please read every question carefully and complete every item on this form in BLOCK CAPITALS.

Completion of this certificate is required in order to assess the ongoing extent of disability. The benefit is normally related to salary and so very substantial amounts can be involved. Full completion of this certificate will result in prompt processing of your patient's claim.

This form must be fully completed and returned to the Income Protection Claims Team, Irish Life. The claimant is responsible for any doctors fees in connection with the completion of this medical questionnaire.

Please provide as much information as possible as this will facilitate prompt assessment of this claim and help avoid the need for further enquiry.

Section 1: Claimant's Details

Name of Claimant

Date of Birth

Name of Employer

Occupation

Section 2: Relationship to Claimant

1. Are you the claimant's usual medical attendant? Yes ◯ No ◯ If yes, how long?
2. When did you first see the claimant with this incapacity?
3. Are you still attending the claimant? Yes ◯ No ◯ If so, date last seen?
4. What is the anticipated frequency of future consultations related to this disablement with you

   Any other treating doctors

Section 3: Nature of Disability

1. Date disability commenced ICD9
2. What is the exact nature and cause of disability?
3. Please describe the exact nature of the symptoms which are preventing your patient from working?
4. Results of all investigations carried out? (Please submit copies of any relevant hospital reports, test results and investigations, as these will speed up the processing of your patient's claim)

5. Are any further investigations/surgery planned? If yes, please give full details below. Yes ◯ No ◯

6. Is your patient, as a result of their condition, restricted in any of the following?

a) Sitting	Yes ◯	No ◯	details	
b) Walking	Yes ◯	No ◯	details	
c) Standing	Yes ◯	No ◯	details	
d) Bending	Yes ◯	No ◯	details	
e) Climbing (i.e. ladders/stairs)	Yes ◯	No ◯	details	
f) Lifting Weights	Yes ◯	No ◯	details	
g) Driving	Yes ◯	No ◯	details	
h) Maintaining concentration	Yes ◯	No ◯	details	

7. Is the patient's condition:

a) Improving?	Yes ◯	No ◯
b) Deteriorating?	Yes ◯	No ◯
c) Static?	Yes ◯	No ◯

8. If the condition is not improving, why is this?

Section 4: Treatment

1. Please provide exact details of current treatment.

2. Please advise on the types and effect of previous treatment regimes?

3. a) Is the treatment providing any relief of symptoms ? If yes, please give full details. Yes ◯ No ◯

b) If no, is a change in treatment currently contemplated? If yes, please give full details. Yes ◯ No ◯

4. Does the patient suffer more than minor side effects as a result of their medication? If yes, please give details. Yes ◯ No ◯

5. To your knowledge is the claimant fully complying with treatment? If no, please provide full details and how this affects management of the condition. Yes ◯ No ◯

Section 5: Extent of Disability

1. a. Is the claimant in your opinion currently able to carry out the duties of his/her normal occupation? Yes ◯ No ◯

   b. If yes, please confirm the exact date on which he/she was fit to do so?

   c. If no, what is the expected duration of work absence as a result of this disability?

   0 - 3 months ◯ 3 months - 6 months ◯ 6 months - 1 year ◯ 1 year - 3 years ◯ 3+ years ◯

2. a. If your patient is currently unfit for his/her normal occupation, what aspects is he/she currently unable to perform?

   b. What aspects is he/she currently able to perform?

3. Is the claimant in your opinion currently fit to resume his/her normal occupation on a part-time basis? If yes, please outline below the nature of work and the number of hours per week that could be performed. Yes ◯ No ◯

4. When in your opinion will he/she be able to resume full time work?

Section 6: Rehabilitation

The policy conditions provide for a reduced benefit to be paid in certain circumstances. Examples of these circumstances could include a return to their normal occupation on a part-time basis or taking up an alternative occupation at lower earnings. This should be financially beneficial to the claimant. With this in mind and with a view to speeding up the rehabilitation process, please advise:

1. a. Do you feel it is in your patient's best interests to resume work as soon as possible? Yes ◯ No ◯

   If no, please explain below in detail:

   b. If it would be in your patient's interest to resume work please advise if you have discussed any of the following?

      i. Return to own occupation - full-time Yes ◯ No ◯

      ii Return to own occupation - part-time Yes ◯ No ◯

      iii. Return to an alternative occupation Yes ◯ No ◯

      If yes to any of the above, please give full details of what is possible and what rehabilitation steps are required in order to achieve this.

   c. If you have not yet discussed return to work options with your patient, do you have any plans to do so? If yes, please give full details including the approximate date on which you intend to have this discussion with your patient. Yes ◯ No ◯

Section 7: Additional Information

Please state any additional information which may be of assistance in the ongoing management of this claim.

Section 8: Other Specialists

Please give the names and addresses of (other) specialists attended.

Name and Address of Speciality of Doctor/Consultant	Date first attended	Date last attended	Date of next appointment

Section 9: Declarations

I certify that I have satisfied myself by personal examination that all foregoing statements are correct.
Please use BLOCK CAPITALS.

Doctor's Name	
Address	
Qualification	
Doctor's Stamp	

Please sign and date

Signature | Date

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Irish Life