

Salesperson:  L.A.R.C No:  Agent/Agency No:

*Please read important Notes overleaf.  
Please complete this form in BLOCK CAPITALS and sign the Declaration*

### Section 1 Life to be insured

Mr.  Mrs.  Ms.

Surname:  Marital status:

First Name:  Date of birth:

Address:

Tel. No:  Home:

Mobile No:

E-mail:

Policy No:

Height:  Weight:  P.P.S.N. No:

How many dependent children do you have  Ages:

Is your spouse employed? Yes:  No:  Spouses Occupation:

### Section 2 Declaration and consent (Not to be signed until the form has been completed)

- I hereby declare that I am the person referred to above, that I have read over the replies to all the questions in this form, that to the best of my knowledge and belief all the information given is true and that I have not withheld any material fact.
- I agree to Friends First seeking information in connection with this claim from any doctor who has at any time attended me or from any other relevant person and I authorise the giving of such information.
- I hereby give my consent to the use and recording of my personal details (contained herein) by both electronic and printed means to Friends First Holdings Limited.

Signature:  Date:

**NOW PLEASE FORWARD THIS FORM TO OUR DUBLIN OFFICE IN THE ENVELOPE PROVIDED TOGETHER WITH:**

- 1. A CURRENT MEDICAL CERTIFICATE**
- 2. A JOB DESCRIPTION IF AVAILABLE**
- 3. EVIDENCE OF INCOME.**
- 4. EVIDENCE OF AGE (Birth certificate, passport or driving licence)**

We need the information in this form, together with any other medical or financial evidence which may be requested, so that we may establish a clear picture of your situation. Failure to answer any question will delay consideration and possibly settlement of your claim. If you fail to disclose a material fact or if you give false information you could render your policy void. It is therefore essential that you provide accurate and comprehensive answers and avoid the use of strokes or dashes. Please read your policy schedule and conditions before completing this form. Answers may be continued on a separate sheet if necessary.

### Section 3 Your employment

1. Who was your employer(s) immediately prior to disability?

Mr.  Mrs.  Ms.

Full Name:  Address:

2. (a) What was your occupation(s) immediately prior to this disability?

**Section 3 Your employment (CONTINUED)**

2. (b) Please describe your normal duties in detail.

(c) What special skills were required?

(d) How many staff were under your control?

3. (a) In what environment did you work (e.g. office, outdoors, factory, etc.)?

(b) Is a driving licence necessary for your job?

Yes:  No:

If so which type:

**Please provide copy of your most recent driving licence**

(c) What machines, equipment or tools did you operate?

(d) Are there any environmental conditions that aggravated your disability (e.g. dust, weather, etc.)?

Yes:  No:

If 'yes', please give details:

4. Did your normal working day involve: (please tick as appropriate)

(a) Climbing ladders or similar?

No	Occasionally	Regularly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(b) Carrying or lifting heavy items?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

(c) Standing?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

(d) Crawling or Kneeling?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

(e) Driving?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

(f) Walking 1/4 mile or more?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

(g) Any other Physical Exertion?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

If so, please specify:

5. (a) Did your job involve travelling, apart from travelling to work?

Yes:

No:

If 'Yes', how many miles a week did you travel?

(b) What form of transport did you use?

6. (a) What hours did you work?

per week

(b) Are there any unusual aspects of your hours of work (e.g. shift work, weekend work or being 'on call')?

Please give details of any other employment(s) you have had during the last five years: (If none, please say so).

Date:	Job titles(s):	Brief description of duties:	Name of employer (or if self-employed):
<input type="text"/>			
<input type="text"/>			
<input type="text"/>			

## Section 4 Your disability

1. (a) What is your disability?

(b) Was this due to an accident?

Yes:  No:

If 'Yes', please give date, time, place and a full description of the accident:

(c) Do you intend to seek compensation or instigate proceedings against any person as a result of your accident or illness, or have you already done so?

Yes:  No:

If 'Yes', please provide full details including the name and address of your solicitor:

2. (a) From what date were you totally disabled under the terms of your policy?

(b) When did you first seek medical advice about this?

(c) Who did you first seek advice from (e.g. doctor, hospital, clinic)?

If date (b) is more than seven days after date (a), please tell us why:

Full name:

Address:

(d) Is this your usual doctor?

Yes:  No:

If 'No', who is your usual doctor?

Address:

(e) Who else have you seen in connection with this disability, eg Company Doctor, (CMO)?

Full name:

Address:

(f) What medication have you received/are you receiving?

(g) What treatment have you received/are you receiving, physio, counselling, etc?

## Section 4 Your disability (CONTINUED)

3. (a) What parts of your job are you (or were you) unable to do?

(b) Are you still unable to do them?

Yes:  No:

If 'No', please give date of recovery:

--	--	--

(c) Have you done any part of your own or any other job, whether paid or unpaid, since the date you have given in question 2(a) (and before the date in 3(b) if applicable)?

Yes:  No:

If 'Yes', please give details:

If 'No', when do you think you will be fit enough to go back to work?

--	--	--

(d) Is there alternative work available should you be able to return to a less demanding activity? If so please give details

(e) What date did you first stop working due to your disability?

--	--	--

Is your job still available for you to return to?

Yes:  No:

4. Have you suffered from this or any similar condition before?

Yes:  No:

If 'Yes', please give details, (including dates and who you consulted):

5. What were your hobbies and pastimes prior to your disability and are you able to continue them? (If 'No' please confirm why this is the case)

## Section 5 Your income prior to disability

### 1. From Employment.

(a) Please give your gross earned income as declared for tax purposes for the period of one year up to the commencement of your disability.

€	
---	--

(b) Please enclose a copy of your last P60

### 2. From Self-Employment.

(a) Please give details of your business.

Name:	Address:	Telephone number:	No. of Partners	No. of Employees

(b) Please enclose your latest available Agreed Notice of Assessment from the Revenue Commissioners and the related Certified Accounts.

(c) Please give your taxable net income for the period of one year up to the commencement of your disability (estimated if necessary).

€	
---	--

(d) Please comment on any significant differences between the incomes indicated in (b) and (c) above.

(e) Please provide us with the name and address of your Accountant:

## Section 6 Your income during disability

### 1. State Benefits

Have you been examined by the Social Welfare? Yes:  No:

What benefit have you received since the end of the deferred period?

(a) Disability Benefit: €

(b) Invalidity Pension (for a single person): €

Adult Dependant benefit: €

Children's benefit: €

(c) Any other State benefits: €

Please specify type of benefit:

**(If your claim for State benefits has been rejected please enclose copies of any relevant letters).**

### 2. Other Insurances

Do you hold any other insurance against disability (including Personal Sickness and Accident policies)? Yes:  No:   
(You should include any policies where benefit is yet to be paid).

If 'Yes', please provide the following details in respect of each policy:

Name of insurer:

Policy number:

Deferred period:

 weeks

Benefit per week:

 € weeks € weeks € weeks €

### 3. Other Income (Ignore investments)

(a) Do you have any loan repayments, mortgage repayments etc? Yes:  No:

If so please give details.

(b) Have you received any other income since the end of the deferred period?  
(You should include any continuing salary, pensions, commissions, etc.)? Yes:  No:

(c) Are you expecting to receive any other income in the future? Yes:  No:

If the answer to either of 3(b) or 3(c) is 'Yes', please provide details:

**Note:** If you were self-employed you should include here any continuing income you have received from your business.

Amount per week:

 €  pw

Start date:

Finishing date:

Amount per week:

 €  pw

Start date:

Finishing date:

(d) If you were self-employed, has your business ceased since you became disabled? Yes:  No:

Are you a sole trader or in a partnership? Yes:  No:

If a partner please confirm your % share of the business  %

If 'No', please give details of any additional expenses you have incurred in maintaining the business:

Amount:

 €

Reason:

 €

**PLEASE CHECK THAT YOUR ANSWERS ARE ACCURATE AND THAT NOTHING HAS BEEN OMITTED.**

Is there anything else that might be helpful to us in assessing your claim?

**NOW COMPLETE THE DECLARATION ON THE FIRST PAGE.**



Friends First Life Assurance Company Limited,  
Friends First House,  
Cherrywood Science & Technology Park,  
Loughlinstown,  
Co. Dublin.  
[www.friendsfirst.ie](http://www.friendsfirst.ie)

Friends First Life Assurance Company Limited  
is regulated by the Irish Financial Services Regulatory Authority.

Friends First is part of the Eureka Group.