

# Group Income Protection

## Employee claim form

**Important Note:**

This form should be completed in as much detail and as accurately as possible. Please note that any incorrect or misleading statements could lead to your claim being denied and the cessation of your membership of the Group Income Protection scheme insured with Generali.

Please ensure that you return this form as soon as possible along with proof of earnings and age/identity (preferably your passport or, if not available, your birth certificate) to enable us to consider the claim in a timely fashion.

Employer's Name:

Policy Number:

**Employee's details:**

Title: Mr/Mrs/Miss/Ms/Dr/other:

Date of Birth:

Surname:

Sex:

Forenames:

Employee No.

Address:

Postcode:

Home Telephone Number:

Mobile Phone:

Personal Email Address:

Height:

Weight:

Are you left or right handed?

Left

Right

Name and age of dependants

	Name	Date of birth
Spouse/Partner		
Children/other dependants		



**Details of incapacity:**

Date first continuously absent from work:

Date symptoms commenced:

When did you first consult your doctor for this condition?

Please describe the nature of the illness or injury that is preventing you from working?:

What aspects of your job are you now unable to carry out and why?:

What would assist you to return to work on either a full time or part time basis?

Are any other factors contributing to your absence from work?

Yes

No

If yes, please give full details:

What current medication is being prescribed and what are the current daily dosages?

What other treatment are you currently receiving? Please give full details:

Are you currently on the waiting list for a specialist referral, or are any other treatment options currently being considered?

Yes

No

If yes, please give full details:

What are your current symptoms?:



**Details of incapacity (cont.):**

Are your symptoms intermittent?

 Yes No

If yes, please give full details regarding the variability of the symptoms you suffer from including details of whether you experience good/bad days or do the symptoms vary throughout the course of the day:

Please describe any modifications you have made to your lifestyle on account of your incapacity:

Is your condition static, improving or deteriorating?

 Static Improving Deteriorating

Please give full details:

Do you feel that you could return to an alternative/modified role?

 Yes No

If yes, please give full details:

When do you think that you will be able to return to work on either a full-time or part-time basis?

GP's name:

Address:

Postcode:

Telephone Number:

Fax Number:

Email Address:



**Details of incapacity (cont.):**

When did you last consult your GP with regard to your current incapacity?

Consultant/Specialist name:

Specialty:

Address:

Postcode:

Telephone Number:

Fax Number:

Email Address:

When did you last consult your Consultant?/Specialist with regard to your current incapacity?

Consultant/Specialist name:

Specialty:

Address:

Postcode:

Telephone Number:

Fax Number:

Email Address:

Consultant/Specialist name:

Specialty:

Address:

Postcode:

Telephone Number:

Fax Number:

Email Address:

When did you last consult your Consultant?/Specialist with regard to your current incapacity?



**Details of occupation:**

In what industry do you work?:

Job title:

What are your contractual hours?:

What hours did you actually work?:

Do you have any managerial/supervisory responsibilities?

Yes

No

If yes, please give full details including the number of staff you are responsible for:

What is your usual working environment? (e.g. office, factory floor, outdoors etc.):

Are there any environmental factors that aggravate your condition?

Yes

No

If yes, please give full details.

Please describe the essential duties of your job:

What qualifications and/or experience are required for your present job?:

Does your job require regular travelling (not including your commute to and from work)?

Yes

No

If yes, please give full details including mode of transport and distances covered.

How far do you travel to and from work and what mode of transport is used?



**Details of occupation (cont.):**

Does your job involve any of the following?

Driving a car	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Driving a van	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Driving a heavy goods vehicle	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Driving/operating other special machinery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prolonged periods in one posture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Climbing ladders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Climbing stairs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bending	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reaching/stretching	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Crawling/kneeling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lifting items in excess of 25kg	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lifting/moving bulky items	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent lifting of smaller/lighter items	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Working with hazardous/toxic materials	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answer yes to any of the above, please give full details.

**Daily activities:**

Please describe your typical day since becoming incapacitated:

Please describe your ability to carry out the following activities of daily living:

Cooking:

Washing dishes:

Laundry:

Ironing:

Vacuuming:

Walking:

**Daily activities: (cont.):**

Sitting:

Driving:

Shopping:

Reading:

Using PC/laptop:

Watching television:

Socialising:

Childcare (if applicable):

Lifting/moving heavy/bulky items:

Lifting/moving small/light items:





**Financial details:**

What was your salary at the date you were first absent?

Are you in receipt of any State benefits?

Yes

No

If yes, please give full details:

Have you, or do you intend to, claim under any other insurance policies as a result of your illness/injury or absence from work?

Yes

No

If yes, please give full details:

Are you in receipt of, or have you applied for an ill-health pension?

Yes

No

If yes, please give full details:

Do you have Private Medical Insurance?

Yes

No

If yes, please give full details:

Are you seeking, or do you intend to seek, compensation as a result of your injury/illness?

Yes

No

If yes, please give full details:

**DECLARATION**

We confirm that the information contained in this form is accurate and complete to the best of our knowledge and belief, and we undertake to advise you of any errors or omissions as soon as they become apparent. We understand that by issuing this form, or by starting the claims process, or by accepting proofs of claim, you shall not be held to admit the validity of any claim nor to have waived any rights of defence in this respect and no liability will be accepted by you until confirmed in writing by authorised officers of Assicurazioni Generali S.p.A.

We undertake to advise Assicurazioni Generali S.p.A. of any change in the member's circumstances, including (but not limited to) any change in their state of health or medical condition, change of address, change in employment status, or the undertaking of any work (whether paid or unpaid).

We authorise Assicurazioni Generali S.p.A. to undertake any enquiries deemed necessary to assess the claim and/or assist us with the management of the absence.

**When you are ready to submit this document please print it, sign it and return it to Generali.  
You can email this form to [grouplclaims@generali.co.uk](mailto:grouplclaims@generali.co.uk) - send by fax to +44 (0) 207 265 6102  
- or send by post to: Claims Dept, Generali Employee Benefits, 100 Leman Street, London E1 8AJ**

SIGNATURE:

DATE:

**Assicurazioni Generali S.p.A. UK Branch 100 Leman Street London E1 8AJ**

Company incorporated in Trieste in 1831 - Share capital €1,556,873,283 fully paid-up - Registered office at Piazza Duca degli Abruzzi 2, Trieste, Italy  
Italian tax identification and companies registry number 00079760328 - Authorised by Istituto per la Vigilanza sulle Assicurazioni (IVASS)  
Registered in the IVASS register of insurance and reinsurance companies under no. 1.00003  
Parent company of Generali Group and entered in the IVASS Register of insurance groups under no. 026  
UK company registration no. BR1185

