Zurich International Group Risk Solutions

Disability assessment claim form

(to be completed by the group member and medical practitioner)

Completing this form

Please complete this form in English using **CAPITAL** letters. If the form is incomplete or inaccurate it will result in delays.

Note: Comprehensive medical evidence is required in order to evaluate the disability claim. **Please ensure you sign the declaration at the end of the form**.

Document submission

It is important you read the instructions below carefully.

1 After completing the form please print, sign and date it.

2 Please scan the signed original form as well as the requested documents and email them to **zigrs.zel@zurich.com**.

3 You must keep the original documents; Zurich reserves the right to collect the original paperwork for a period of 12 months after receipt of the claim form.

4 Alternatively, you may choose to send the original documents by post to Zurich Eurolife S.A., Building Elise, 21 rue Léon Laval, L-3372 Leudelange, Luxembourg.

If there is insufficient space for any answer, please continue on a separate piece of paper and attach it to this form. Please tick here if a separate sheet is attached ☐

Policy details

Policyholder name	VODAFONE GMBH
Policy number	20396

1. Details of group member

We adhere to strict confidentiality procedures when we communicate and will regard the details you provide as your authorized contact details. It is therefore important that they are accurate and that you let us know if any of these details change.

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other *(please give details)*

Forename(s)

Family name

Please give details of any previous names or aliases used (including maiden name)

Date of birth D D M M Y Y Y Y

Start date of employment D D M M Y Y Y Y

These details MUST be completed in order to process your claim.

Address

Mobile phone number

Telephone number

Email address

By providing my email address I authorize Zurich to contact me and send me information or data by email.

2. Situation report (to be completed by the group member)

1. What is your education and work history?

Education
Work History

2. What was your occupation immediately prior to this disability?

3. What were your duties in occupation (please give % of time spent on each duty)?

Duties	% of time spent

4. Which medical practitioner is most familiar with your medical history?

Name of medical practitioner

Address

5. What is the nature of your present disability (if due to an accident, please also give full details of circumstances and date of occurrence)?

Disability	Circumstances	Date of occurrence

Situation report (to be completed by the group member) (continued)

6. Are you able to carry out any part of your occupation? ☐ Yes ☐ No

If 'Yes', please state duties and % of time spent on the duty

Duties	% of time spent

If 'No', please state reasons.

7. Are you able to carry out a different occupation? ☐ Yes ☐ No

If 'Yes' please state what occupation

Occupation

If 'No', please state reasons.

8. Date of first medical consultation with regard to this disability. D D M M Y Y Y Y

9. For what period of time have you been absent from work due to this disability?

Full time – from D D M M Y Y Y Y to D D M M Y Y Y Y or ongoing ☐

Part time – from D D M M Y Y Y Y to D D M M Y Y Y Y or ongoing ☐

10. When is it expected for you to be back at work?

Full time – from D D M M Y Y Y Y

Part time – from _____ % D D M M Y Y Y Y

11. Have you consulted any other doctors/hospitals/clinics? ☐ Yes ☐ No

If 'Yes', please give details.

12. Are you receiving any state or government benefit? ☐ Yes ☐ No

If 'Yes', please give details.

Type of benefit	Amount of benefit	Frequency of benefit	Start of benefit	End of benefit

13. Are you in receipt of or have you applied for an ill health or early retirement pension? ☐ Yes ☐ No

If 'Yes', please give details.

Type of benefit	Amount of benefit	Frequency of benefit	Start of benefit	End of benefit

Situation report (to be completed by the group member) (continued)

14. Are you in receipt of any other benefit from an individual policy covering this disability? ☐ Yes ☐ No

If 'Yes', please give details.

Type of benefit	Amount of benefit	Frequency of benefit	Start of benefit	End of benefit

If you have answered 'Yes' to questions 12, 13 or 14 please provide supporting statements.

Data Protection and Professional Secrecy

In accordance with the applicable Luxembourg data protection law (including but not limited to the Luxembourg law of 1 August 2018 organizing the National Commission for data protection and the general system on data protection and the European Regulation no. 2016/679 of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (the '**GDPR**')) (the '**Data Protection Law**'), Zurich Eurolife S.A. as data controller collects, stores and processes, by electronic or other means, your personal data including but not limited to: title, family name, forename(s), country and place of birth, nationality, date of birth, date of the beginning or ending of the employment, residential address, country/countries of residence, health information if applicable, tax identification number if applicable, email address, telephone number, gender, marital status and employment as well as financial details (the '**Personal Data**').

The lawful basis for the Personal Data processing are (i) your consent for the processing of your health information (where applicable), (ii) the legitimate interests of Zurich Eurolife S.A. and the legitimate interests of the parties benefiting from the policy and (iii) compliance with applicable legal and regulatory obligations relating e.g. to fraud prevention and detection, anti-money laundering rules, tax reporting requirements, economic or financial sanctions laws and the legal and regulatory requirements applicable to insurance companies. In this regard, Personal Data is processed in particular for purposes of:

a) The subscription, performance, servicing and administration of the policy (including but not limited to provide insurance cover, to pay for a claim or to manage the risk associated to the insurance coverage through reinsurance);

b) The provision of related assistance services, advice and support;

c) Underwriting and claim management purposes;

d) IT services, including but not limited to the provision of IT infrastructure, IT maintenance services, IT security and data analytics, administration of websites, troubleshooting, data analysis, testing, research, statistical and survey purposes;

e) Preventing and detecting fraud, money laundering or terrorist financing and risks of violating economic or financial sanctions laws on the level of the Zurich Insurance Group Ltd. or any of its affiliated companies, as listed in the most recent annual accounts ('**Zurich Group**');

f) If necessary, for the establishment, exercise or defense of legal claims;

g) Where applicable, negotiating a possible sale, transfer or reorganization of our or our Group's business (or any part of it); and

h) Complying with all applicable legal and regulatory obligations (e.g. to prevent and detect fraud, money laundering or terrorist financing, to comply with tax reporting requirements and economic or financial sanctions laws and to comply with the legal and regulatory requirements applicable to insurance companies).

The 'legitimate interests' refer to the above points a) to g) as well as to benefiting from the policy as regards the parties benefiting from the policy.

The provision of Personal Data, including health data where applicable, by you is required for the performance of the policy. Failure to provide sufficient, accurate and up-to-date information as well as failure to provide consent regarding the processing of your health data, where applicable, may prevent Zurich Eurolife S.A. from providing cover.

Considering our outsourcing and service provider arrangements, covering notably the assistance described above under points a) to h), and the fact that we operate in several jurisdictions in which we may be required to share Personal Data with local authorities, affiliates or other third parties, the Personal Data may be disclosed or transferred to third parties for the above-mentioned purposes. This may, depending on circumstances, include the parties listed below (the '**Recipients**'):

- Zurich Group; Companies in the Zurich Group share information with each other in the context of outsourcing and service provider arrangements. Information is shared where it is relevant and appropriate; this includes health information for underwriting and claims purposes or where necessary for IT servicing or security purposes. If you apply for insurance with more than one company in the Zurich Group, they may share your details;
- Involved financial advisers, brokers, agents or other insurance intermediaries;
- Other contractors or service providers who may provide services to us such as administration, information technology, telecommunication, actuarial, data entry, data storage, data recovery, data security, mail distribution, claim assessment and adjudication, payment, investment, check printing, fiscal representation, marketing, emergency assistance services, due diligence screening, auditors, lawyers, medical and professional services as well as survey and research services;
- Credit reference agencies, reinsurers, other insurers and financial institutions;
- On the sale, transfer or reorganization of our or our Group's business (or any part of it) to the acquirer or new organizational unit; and
- Governmental, legal, tax and regulatory authorities, courts, dispute resolution forums (which have jurisdiction over us or our Group companies), investigators or legal process participants and their advisors.

The Recipients are established within the European Union ('**EU**'), the European Economic Area ('**EEA**'), the United Kingdom, the Isle of Man, Switzerland and Hong Kong. Where we transfer Personal Data outside the EU or the EEA, we will ensure that the transfer relies on one of the legitimacy basis set out by the Data Protection Law. We will do this by ensuring that there is either an adequacy decision of the EU Commission regarding the transfer of Personal Data or that the Personal Data is given adequate safeguards by using 'standard contractual clauses' which have been adopted by the EU Commission or, as the case may be, any other legitimacy basis provided for by the Data Protection Law. The Isle of Man and Switzerland benefit from an adequacy decision of the EU Commission. You have a right to request a copy of the 'standard contractual clauses' from the Data Protection Officer of Zurich Eurolife S.A.

The Recipients may, under their own responsibility, disclose the Personal Data to their agents and/or delegates (the '**Sub-Recipients**'), which shall process the Personal Data for the sole purposes of assisting the Recipients in providing their services to Zurich Eurolife S.A. and/or assisting the Recipients in fulfilling their own legal obligations. The Recipients and Sub-Recipients may, as the case may be, process the Personal Data as data processors (when processing the Personal Data on behalf and upon instructions of Zurich Eurolife S.A. and/or the Recipients), or as distinct data controllers (when processing the Personal Data for their own purposes, notably to fulfil their own legal obligations). Where we transfer Personal Data to Recipients acting as data processors, we will ensure that where such Recipients further transfer Personal Data to Sub-Recipients outside the EU or EEA, such transfer relies on one of the legitimacy basis set out in the preceding paragraph.

The Personal Data shall not be kept by Zurich Eurolife S.A. for any period longer than necessary, with respect to the purposes of the data processing, including compliance with applicable statutory retention periods or limitations.

In accordance with the conditions laid down by the Data Protection Law, you have the right to:

- Access your Personal Data;
- Correct your Personal Data where it is inaccurate or incomplete;
- Object to the processing of your Personal Data;
- Ask for erasure of your Personal Data;
- Ask for the restriction of processing of your Personal Data; and
- Ask for Personal Data portability – to obtain personal information in a digital format.

You may exercise your above rights by writing to the Data Protection Officer of Zurich Eurolife S.A. at the following address:

Data Protection Officer
Zurich Eurolife S.A.
Building Elise
21 rue Léon Laval
L-3372 Leudelange
Luxembourg

E-mail: ZELprivacy@zurich.com

You also have the right to lodge a complaint with the Luxembourg National Commission for Data Protection ('**CNPD**') at the following address: 1, Avenue du Rock'n'Roll, L-4361 Esch-sur-Alzette, Luxembourg; or with any competent data protection supervisory authority of your EU or EEA member state of residence.

☐ I explicitly consent to the processing of my health data by Zurich Eurolife S.A. and its Recipients and Sub-Recipients, as set out in the Data Protection and Professional Secrecy clause above, for the purposes of underwriting life insurance cover and for the provision of related assistance services, advice and support.

This consent may be withdrawn at any time by writing to the Data Protection Officer of Zurich Eurolife S.A. The withdrawal of my consent will not affect the data processing carried out prior to such withdrawal. I am also informed that where necessary for the establishment, the exercise or the defence of a legal claim, my health data may be processed by Zurich Eurolife S.A. and its Recipients and Sub-Recipients without my consent.

If I refuse to give the above consent, I understand that provision of life insurance cover and related assistance services, advice and support may be delayed or denied, if the remaining sources of information do not make it possible to investigate and assess the risk or provide appropriate assistance, advice and support associated with my request.

Signature of group member

Date D D M M Y Y Y Y

3. Confidential medical certificate (to be completed by the attending medical practitioner)

Please provide details of all available hospitalisation reports, x-rays, etc.

1. Do you know or have you ever previously attended the patient? ☐ Yes ☐ No

If 'Yes', please advise in what capacity you know the patient, i.e. professional or personal.

2. Date of first consultation with regard to the disability D D M M Y Y Y Y

Confidential medical certificate (to be completed by the attending medical practitioner) (continued)

3. Date of last medical consultation with regard to this disability? D D M M Y Y Y Y

(a) Please state current height and weight of patient.

Height cm Weight kg

(b) Please give blood pressure reading.

Systolic mmhg Diastolic mmhg

4. Please provide full details of the current diagnosis according to ICD-10 or DSM-IV

ICD-10 DSM-IV

5. Please provide full details of any illness or disability from which the patient is now suffering (please attach any supporting reports, x-rays, etc.).

6. Please provide details of past and current medical treatment undergone in connection with this disability.

(a) Full details of all medication being prescribed for the patient, including dosage.

Name and dosage of medication

(b) Details of any surgical procedure performed in connection with the current condition.

Date	Surgical procedure	Result

(c) Details of any other treatment being prescribed, including physiotherapy.

Date/duration	Type and nature of treatment	Result

Please provide the address of physiotherapist or other therapist.

Name

Address

(d) Do you anticipate changing the patient's treatment in the immediate future or recommending that they undergo further investigations or surgical procedures? ☐ Yes ☐ No

If 'Yes', please give details.

Confidential medical certificate (to be completed by the attending medical practitioner) (continued)

(e) Has the patient been seen as an out patient by any consultant, specialist or other member of the medical profession in connection with the current condition? ☐ Yes ☐ No

If 'Yes', please give details.

Date	Type of specialist/treatment	Result

Please state full address details of consultant/specialist.

Name

Address

(f) Is the patient still receiving treatment from any other medical practitioner? ☐ Yes ☐ No

If 'Yes', please give details.

Date	Type and nature of treatment	Result

7. For what period of time has the patient been absent from work due to this disability?

Full time – from D D M M Y Y Y Y to D D M M Y Y Y Y or ongoing ☐

Part time – from D D M M Y Y Y Y to D D M M Y Y Y Y or ongoing ☐

8. Is the patient capable of carrying out any part of the duties of their own occupation? ☐ Yes ☐ No

If 'Yes', please give details, if 'No' please state reasons.

9. Is the patient capable of carrying out a different occupation? ☐ Yes ☐ No

If 'Yes', please give details, if 'No' please state reasons.

10. (a) Are you aware of anything in the patient's medical history likely to be connected with this current disability? ☐ Yes ☐ No

If 'Yes', please give details.

(b) Are you aware of any factors which might interfere with the healing process? ☐ Yes ☐ No

If 'Yes', please give details.

Confidential medical certificate (to be completed by the attending medical practitioner) (continued)

11. What is the degree of work capacity at this time

(a) with regard to their own occupation?

Work capacity ____ % Type of possible duties ____

(b) with regard to a similar occupation?

Work capacity ____ % Type of possible duties ____

(c) with regard to any other gainful occupation?

Work capacity ____ % Type of possible duties ____

12. Please describe any limitation due to the current disability

Standing ____ Climbing ____

Sitting ____ Bending ____

Walking ____ Use of hands ____

Driving ____ Psychological ____

Lifting ____

Dependent on a third person for daily life

____

Other restriction in movement or lifestyle

____

13. When do you estimate the patient will be able to return to work?

Full time – from D D M M Y Y Y Y

Part time – from ____ % D D M M Y Y Y Y

14. What is your prognosis for the patient?

15. Additional comments

Please include here any further information which in your opinion would assist in the assessment of the claim and any measures that could improve the patient's capacity to work.

Please ensure that all questions are answered and the patient has signed the declaration.

If you detected some abnormality which the patient may or may not be aware of, and which you consider requires further investigation, then please state the abnormality detected and advise what course of action you have taken/advised in the box below.

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- Involved financial advisers, brokers, agents or other insurance intermediaries;
- Other contractors or service providers who may provide services to us such as administration, information technology, telecommunication, actuarial, data entry, data storage, data recovery, data security, mail distribution, claim assessment and adjudication, payment, investment, check printing, fiscal representation, marketing, emergency assistance services, due diligence screening, auditors, lawyers, medical and professional services as well as survey and research services;
- Credit reference agencies, reinsurers, other insurers and financial institutions;
- On the sale, transfer or reorganization of our or our Group's business (or any part of it) to the acquirer or new organizational unit; and
- Governmental, legal, tax and regulatory authorities, courts, dispute resolution forums (which have jurisdiction over us or our Group companies), investigators or legal process participants and their advisors.

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I hereby confirm that I have questioned and examined the patient and have answered the above questions to the best of my knowledge and in good faith.

Signature of medical practitioner

Date D D M M Y Y Y Y

Name (in full)

Professional qualifications

Address

Medical practitioner's telephone number

Medical practitioner's email address

Stamp of medical practitioner

Important: the medical practitioner is requested to refrain from giving the patient any information which might interfere with our or our nominated insurer's claims assessment.

Zurich Eurolife S.A. is a life insurance company incorporated under the laws of Luxembourg and registered with the Luxembourg register of commerce and companies under no. B51753.

Registered office: Building Elise, 21 rue Léon Laval, L-3372 Leudelange, Luxembourg.
Telephone +352 26 642 1 Fax +352 26 642 650 Email lux.info@zurich.com

www.zurich.lu.

VAT no. LU 1660 2944.

Zurich Eurolife S.A. is subject to the applicable Luxembourg legislation and falls under the supervision of the Luxembourg insurance regulator, the Commissariat aux Assurances (7, boulevard Joseph II, L-1840 Luxembourg, Luxembourg).

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