

For Office Use Only

Registration Number:

PERSONAL INFORMATION

Title*:

First Name*: Second Name:

Surname*:

Name to appear on correspondence*:

PPS Number*:

Irish Medical Council Registration Number*:

Specialist division on the IMC Register (see overleaf for list):

Correspondence Address:

Practice Address*:

Hospital 1 Name*: Hospital 3 Name*:

Address: Address:

Hospital 2 Name*: Hospital 4 Name*:

Address: Address:

Contact Telephone Number*: Contact Fax Number:

Contact E-Mail Address*: Contact Mobile Number:

Please provide your bank account details below in order to facilitate direct payment:

Bank Name:

Bank Address:

Bank Account Name:

Account number - IBAN:

To enable us to retain accurate records, please include your specialty*: (please tick)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> ANAESTHESIA | <input type="checkbox"/> GENERAL SURGICAL | <input type="checkbox"/> OPHTHALMOLOGY | <input type="checkbox"/> RADIOLOGY |
| <input type="checkbox"/> CARDIOLOGY | <input type="checkbox"/> GYNAECOLOGY | <input type="checkbox"/> ORTHOPAEDIC | <input type="checkbox"/> RADIOTHERAPY |
| <input type="checkbox"/> CARDIO-THORACIC | <input type="checkbox"/> MAXILLOFACIAL / ORAL SURGERY | <input type="checkbox"/> OTOLARYNGOLOGY | <input type="checkbox"/> RESPIRATORY |
| <input type="checkbox"/> DENTAL SURGEON | <input type="checkbox"/> NEUROLOGY | <input type="checkbox"/> PAEDIATRIC | <input type="checkbox"/> RHEUMATOLOGY |
| <input type="checkbox"/> DERMATOLOGY | <input type="checkbox"/> NEUROSURGERY | <input type="checkbox"/> PATHOLOGY | <input type="checkbox"/> SPORTS MEDICINE |
| <input type="checkbox"/> EAR, NOSE AND THROAT | <input type="checkbox"/> OBSTETRICS & GYNAECOLOGY | <input type="checkbox"/> PHYSICIAN | <input type="checkbox"/> THORACIC |
| <input type="checkbox"/> EMERGENCY MEDICINE | <input type="checkbox"/> OCCUPATIONAL MEDICINE | <input type="checkbox"/> PSYCHIATRY | <input type="checkbox"/> UROLOGY |
| <input type="checkbox"/> GASTROENTEROLOGY | <input type="checkbox"/> ONCOLOGY CARE | <input type="checkbox"/> PLASTIC SURGERY | |

Will you be (please tick relevant box)*:

Fully accepting Irish Life Health payment rate?

Not accepting Irish Life Health payment rate?

Please attach: • Copy of letter of appointment as a consultant in Ireland
• Brief Curriculum Vitae

DATA PROTECTION

Irish Life Health dac is registered with the Office of the Data Protection Commissioner to act as a data controller and data processor in relation to the information you provide about yourself. The information you have provided will be used to administer and pay claims and for the operation of anti-fraud policies on financial services provided by us. We will share this information with our third party administrators and any other commercial entity for the purposes above and as required to provide our services and in order to comply with legal obligations imposed on us. We may share and use this information both inside and outside of the European Economic Area, in confidence, for these purposes.

You have a right (subject to applicable data protection legislation) to obtain a copy of the personal information we hold about you. In order to obtain a copy of such information, please write to: Irish Life Health, Lower Abbey Street, Dublin 2. Please enclose a fee of €6.35 with your request. Should you discover any errors or omissions in the personal information held by us, you may have the right to have such errors corrected, blocked or erased, free of charge, so please contact us by writing to us at the address above.

Declaration

I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I/we confirm that I/we am/are giving my/our permission to you to use the information I/we have given on this form for the purposes set out in the Data Protection section above.

Print name in block capitals:

Your signature:

Date:

*Mandatory fields

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