

Claim form

Fatal accident

Data protection

We use personal information which you supply to us [or, where applicable, to your insurance broker] for underwriting, policy administration, claims management and other insurance purposes, as further described in our Master Privacy Policy, available here: <https://www2.chubb.com/uk-en/footer/privacy-policy.aspx> or by searching 'Master Privacy Policy' on <https://www2.chubb.com/uk-en/>. You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at dataprotectionoffice.europe@chubb.com.

Please write in black ink and use block capital letters.

All sections must be completed or marked 'not applicable'.

Complete the checklist and ensure that you sign the declaration at the end of this form.

Policy number

Main Policy holder details

Title	First name	Last name
<hr/>	<hr/>	<hr/>
Email address	Date of Birth (DD/MM/YY)	
<hr/>	<hr/>	
Full address		
<hr/>		
		Postcode
<hr/>		<hr/>
Contact no. (day)	Contact no. (eve)	
<hr/>	<hr/>	

For security purposes please provide a password which will be required to access your claim information
 This is for additional security and you may be asked for it when calling Chubb.

Insured persons details

Full name	Date of Birth (DD/MM/YY)	Relationship to main policy holder	I intend to claim on behalf of: (✓) where applicable
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Employment details

What is your occupation? _____

Please describe your duties: _____

Name & Address of employer: _____

Email address of employer: _____

Claimant details

Claimant Name (Mr, Mrs, Miss, Ms): _____ Date of birth: _____

Address (if different from above): _____

What is your relationship to Insured Person: _____

Telephone number (Business): _____ Telephone number (Home): _____

Email address of employer: _____

Accident details

Please give exact date and time when injured: Date: _____ Time: _____ am/pm

Please give the date of death: _____

A certified Copy of the full Death certificate will be required when issued

Please state full particulars of how the accident occurred: _____

Were there any witnesses? Yes: No:

If Yes, please provide names and addresses: _____

Please give full name and address of the Insured Person's General Practitioner: _____

Please give full name and address of Coroner who will be conducting the Inquest _____

Please give date Inquest held or planned: _____

Access to Medical Reports Act 1988

Before your doctor can give a medical report on this claim form which is a requirement of this claim, you must give your consent. Before giving your consent, you should be aware of your rights under the act which are summarised as follows:

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of this report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the Doctor to amend any part of the report which you consider to be incorrect or misleading. If the Doctor does not agree with your request you may attach your comments to the report.

NB: The Doctor may withhold all or part of the report from you if he considers that you may be physically or mentally harmed by it'

Patient Declaration

Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my claim

1. I hereby consent to Chubb seeking medical information from any Doctor who at any time has attended me concerning conditions which affect my physical or mental health.
2. I do wish to see the report before it is sent to Chubb
 I do not wish to see the report before it is sent to Chubb
3. I authorise such Doctor to disclose such information to Chubb.
4. I agree that a copy of this consent shall have the validity of the original.

Payee's bank details

If we approve your claim, we can credit the money direct to your bank account. This method is quicker, safer and more reliable than payment by cheque. If you would like us to do this, please complete the following:-

Name of your Bank/Building Society: _____

Bank Sort Code

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Address: _____

IBAN _____

BIC _____

Account Number _____

Name of Account Holder (s) _____

Postcode _____

Declaration

I declare that all the information given is to the best of my knowledge and belief, full true and correct.

I give permission for any Medical Practitioner, Law Enforcement Agency or Statutory/Regulatory Authority mentioned with respect to this claim, to release information regarding my records.

Signed

Name _____

Date _____

Checklist

Please return the completed claim form together with any enclosures to your insurance broker or Chubb and please ensure:

- You have completed **all** questions on this claim form included any marked 'N/A'
- You have enclosed all requested information/documentation
- You have signed the declaration section

If you do not complete all sections and provide all requested documentation your claim will be delayed.

Chubb. Insured.SM

We use personal information which you supply to us for underwriting, policy administration, claims management and other insurance purposes, as further described in our Master Privacy Policy, available here <https://www2.chubb.com/uk-en/privacy-policy.aspx> or by searching 'Master Privacy Policy' on www.chubb.com. You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at dataprotectionoffice.europe@chubb.com.

Chubb European Group SE is an undertaking governed by the provisions of the French insurance code with registration number 450 327 374 RCS Nanterre and the following registered office: La Tour Carpe Diem, 31 Place des Corolles, Esplanade Nord, 92400 Courbevoie, France. Chubb European Group SE has fully paid share capital of €896,176,662 and is supervised by the Autorité de contrôle prudentiel et de résolution (ACPR) 4, Place de Budapest, CS 92459, 75436 PARIS CEDEX 09.
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