



FATAL ACCIDENT CLAIM FORM

RETURN TO:

THE CLAIMS DEPARTMENT, COMPASS UNDERWRITING LTD, 1-2 CRUTCHED FRIARS, LONDON. EC3N 2HT

PLEASE COMPLETE ALL QUESTIONS – IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE “N/A”.

Name of Policyholder: _____
Certificate/Policy No. _____

Full Name of Insured Person _____	Date of Birth _____
(Mr, Mrs, Miss, Ms) _____	Date of Death _____
Full Address: _____	

_____	Postcode _____

EMPLOYMENT DETAILS
Occupation/Duties _____
Name and Address of Employer _____

CLAIMANT DETAILS	
Claimant Name (Mr,Mrs,Miss,Ms) _____	Date of Birth _____
Address (if different to above) _____	

_____	Postcode _____
What is your relationship to Insured Person _____	

ACCIDENT DETAILS

Please give the exact date and time of the accident: Date: _____ Time: _____ AM/PM _____

A Certified Copy of the full Death Certificate should be enclosed with the claim form.

Please state full particulars of how the accident occurred: _____

Were there any witnesses YES/NO _____

If YES, please provide names and addresses _____

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

Please Give the full name and address of HM Coroner who will be conducting the Inquest: _____

Please give the date of the inquest held or planned _____

DECLARATION

I hereby declare that the above statements are true in every respect to the best of my knowledge and belief and that I have disclosed all information likely to influence the assessment of this claim. I consent to the seeking of information from the insured's present employer and any doctor who has treated them or any person/organisation we deem necessary, to check the answers I have provided, and I authorise the giving of such information. A copy of this authorisation shall be considered as effective and valid as the original. I understand and agree that information regarding this claim may be shared with other insurers and the Benefits Agency for fraud prevention purposes and that I consent to this claim being investigated as part of this process.

DATA PROTECTION ACT 1998 I hereby consent to any information you have about the insured being processed by you for the purposes of providing insurance and claims handling, which may necessitate your providing such information to third parties

Signed.....Date

PLEASE ENSURE



As failure to do so will result in delay in handling your claim.

You have completed ALL relevant questions on this claim form.

You have enclosed all requested information/documentation.

You have signed this claim form.