KEANEY INSURANCE BROKERS LTD.

Fórsa Life Assurance Claim Form

THIS CLAIM FORM IS TO BE COMPLETED BY A FORSA MEMBER IN THE EVENT OF DEATH OF THEIR SPOUSE.

Definition of Spouse:

An eligible member's partner in marriage or;
An eligible member's partner under a civil registered partnership or;
Where an eligible member has been co-habiting with a partner for a minimum of 2 years.

Important note:

Claims will not be considered in the following circumstances:

1) The Spouse was **aged over 70** at time of death
2) The Spouse had previously received **a Critical Illness benefit** under the Forsa policy.

Please complete and sign the Form and forward along with the requested documentation to:

Keaney Insurance Brokers Ltd
30 Lower Leeson Street
Dublin 2

Full Name of Deceased: _____

Alternative name: (if also known by any other version of name) _____

Date of Death: _____

Name of person completing this form: _____

Relationship to Deceased: _____

Approximate date you joined Fórsa: _____

Employer: _____

Workplace address: _____

_____

_____

Email address: _____

Grade/Jobcategory: _____

If the deceased was a member of a union prior to 2nd January 2018, please confirm which union:

IMPACT ☐
CPSU ☐
PSEU ☐

KEANEY INSURANCE BROKERS LTD.

Please provide a copy of the following documentation to enable your claim to be assessed:

Document attached	YES	NO	Comment
1) A certified copy of Death Certificate (An interim Death Certificate will not suffice)	☐	☐	
2) A certified copy of Marriage Certificate	☐	☐	
3) Other proof of name change (if applicable)	☐	☐	
4) Evidence of cohabitation:			
a) A joint bank account	☐	☐	
b) A utility bill	☐	☐	
c) Other document	☐	☐	

Please provide the name and address of the deceased's General Practitioner?

GP Name: _____

Surgery Address:

Street: _____

Town: _____

Post Code: _____

Contact:

Work Tel: _____

Email: _____

Data Protection Act 1998

I understand and consent to the use of any information provided by me for the operation of this insurance. This includes the process of underwriting, administration, claims management, rehabilitation and handling customer concerns.

I understand that in order to do this the information may be shared with other insurers, re- insurers, insurance intermediaries and service providers who are involved in either the operation of insurance, which covers members or the member's benefits arrangements provided by the company.

I understand the data will be processed fairly and securely in accordance with the Data Protection Act 1998 and the details will be stored on computer, but will not be kept for longer than necessary.

I confirm that the data in relation to this insurance has been obtained and passed to: Sedgwick in accordance with the requirements of the Data Protection Act 1998.

DECLARATION

I hereby certify that the foregoing information is true and correct and I agree that any statement made by me and found to be false shall surrender all my rights under my policy at the option of Underwriters. I understand that Sedgwick will verify my membership details with Fórsa.

I hereby authorise any hospital, physician, employer or any other person to furnish all information as requested by Sedgwick or its representative in consideration of the claim.

Copies of this declaration will be legally valid.

I understand that this form will be passed to or used by member companies of Sedgwick and Underwriters for the purpose of my insurance. This includes underwriting, processing, claims handling, membership verification by Fórsa and fraud prevention, which could include passing details to agents of Sedgwick or other insurers. You may ask other insurers for information to check the information I have given.

Sedgwick's "caring counts"® commitment is to value the right of privacy of the companies and individuals we serve. It is Sedgwick's policy to comply with all applicable privacy and data protection laws and maintain the trust of those we serve.

We want to share with you our policy to what personal information we may collect, how we may use this information and other important areas relating to your privacy and data protection. Please find below links to the policies that apply to all internet sites and applications of Sedgwick and its groups of companies.

Introduction and scope
Sedgwick, its subsidiaries and affinities ("Sedgwick," "we," "us," "our,") take your privacy seriously.

This Privacy Notice describes the types of Personal Data that we obtain through the Sites and Services (each as defined below), how we may use that Personal Data, with whom we may share it, and how you may exercise your rights regarding our processing. The Notice describes the measures we take to safeguard the Personal Data that we obtain and how you can contact us about our privacy practices. We conclude by describing further specific rights that may be available in your jurisdiction.

"Personal Data" is information that identifies you or other individuals (such as your dependents). This Privacy Notice describes how we will handle Personal Data that we collect through our websites and other software applications made available through computers and mobile devices (the "Sites") and Claims handling, loss adjusting, or similar processes such as claim forms, telephone calls, e-mails and other communications with us, as well as from claim investigators, medical professionals, witnesses or other third parties involved in our business dealings with you (the "Services").

Contact
If you have questions about this Privacy Notice or about Sedgwick's privacy practices, please contact our privacy team via e-mail at privacyissues@sedgwick.com or by post at 8125 Sedgwick Way, Memphis, TN 38125.

By signing this form, I confirm that I have read and understand the Privacy Policy.

Claimant's Details:

Name: _____

Address:
Street: _____
Town: _____
Post Code: _____

Contact:
Work Tel: _____
Mobile Tel: _____
Email: _____

Signature: _____ **Dated:** _____

The Life benefit sum assured is € 5,000.00 and once approved, claims settlement will be made by electronic transfer to your chosen bank account:

BANK DETAILS

Bank Name: _____

Bank Address: _____

_____

_____

Name on Account: _____

Bank Sort Code: _____

Bank Account Number: _____

IBAN: _____

Form of Discharge – Term Life Insurance

Deceased's Name: _____

I/We the undersigned as Executor(s)/administrator(s)/Next of kin (delete as appropriate), hereby request Bulstrad Life. Vienna Insurance Group, to pay the sum of Euro 5,000, this being the amount due under this policy, in full and final settlement of this claim.

I do hereby discharge the Bulstrad Life. Vienna Insurance Group from any further liability whatsoever in respect of this claim.

All benefits will become payable upon receipt of this signed declaration.

Signature of Legal Beneficiary: _____

Title / Name: _____

Dated: _____