NEW IRELAND ASSURANCE

Death Claim Form

Please complete in **BLOCK CAPITALS** and tick (✓) where appropriate

We take your privacy seriously. It is important that you know how we protect and use your data. This is set out in our Data Privacy Notice which is available on our website www.newireland.ie/options/data-privacy-notice/ or we can send you a copy by calling us on the 01 523 9810 where a member of our Customer Service Team will be happy to help you.

- Please answer all questions fully to avoid any undue delay in considering your claim. If you fail to disclose all relevant information or if you give false information you could render your insurance void.
- Please note this form is not an admission of liability by New Ireland Assurance. On receipt of your claim form we will assess your claim and we will communicate with you when this process has been completed.
- Please return this form to: Risk Claims Department, New Ireland Assurance, 5-9 South Frederick Street, Dublin 2.
  Tel: 01 617 2974. Fax: 01 617 2050. Email: claim@newireland.ie
  Please ensure if sending personal data (especially sensitive personal data i.e. medical information) by email that appropriate security measures (including encrypting the data) are taken to comply with relevant regulatory obligations.

Policy Number:

1. Claim details

Name of Deceased:

Address of Deceased:

Date of Death: D D M M Y Y Y Y

Deceased's Date of Birth: D D M M Y Y Y Y

Name of Claimant:

Address of Claimant:

Capacity of Claimant:

(e.g., an executor, administrator, trustee, assignee or policyholder)

Phone Number of Claimant:

2. Medical details - Please note this is not required for Investment/Savings policies

The name and address of the deceased Life Assured's normal GP and also, if relevant, the name and address of the Hospital Consultant who attended the deceased Life Assured:

Medical Information Authorisation

I/we authorise to New Ireland Assurance seeking information from any doctor who at any stage has attended the deceased life assured concerning his or her physical or mental health or seeking information from any insurance office to which a claim has been made and I/we authorise the giving of such information.

Signature of Next of Kin:

Date: D D M M Y Y Y Y

3. Payment details

Following the admittance of the claim please pay the proceeds to the person shown below.

By EFT payment to the following bank account*

Account Holder Name(s):

Account Number (IBAN):

Swift BIC:

(your bank will be able to confirm these details if necessary)

Bank Name:

Address:

4. Declaration

I confirm I have been informed about the New Ireland Data Privacy Notice and where to find it.

I/we declare that I/we are legally entitled to claim the amount payable under the above policy. The details shown above are true and complete. Following New Ireland's acceptance of the claim, please pay the proceeds of this policy to the person or to the bank account as shown above.

I authorise New Ireland Assurance seeking information in connection with this claim form from any source the Company deems necessary and I authorise the giving of such information.

I understand and authorise that New Ireland Assurance and its duly authorised agents may hold and use the information on computer file, in any other dematerialised form or in written hard copy on it's own behalf and may use or pass the information to third parties (including, where relevant, specialist or private investigators) for matters in connection with the investigation and processing this claim and for administration, regulatory, customer care and service purposes. I agree that New Ireland Assurance or a duly authorised agent of New Ireland Assurance may contact me in person, by phone, by email, or by letter.

I understand that the information I provide to New Ireland Assurance as part of my claim will be processed by New Ireland Assurance to assess and review my claim and cross reference particulars of my claim in insurance industry database for fraud prevention purposes. I accept that in certain cases, this may involve the sharing of my information with other insurance providers and private investigators. I understand and accept that New Ireland Assurance reserves the right to instruct a private investigator to investigate a claim

"Information" means any information including medical and non-medical information given by me or on my behalf in connection with this claim or any further information which may be given at a later stage either in writing, by email, at a meeting or over the telephone.

Signature of Claimant 1:

Date: D D M M Y Y Y Y

Signature of Claimant 2:

Date: D D M M Y Y Y Y

New Ireland Assurance Company plc.,
5-9 South Frederick Street, Dublin 2. **T:** (01) 617 2974 **F:** (01) 617 2050. **E:** Claim@newireland.ie **W:** www.newireland.ie