Chubb European Group SE
Travel Insurance Claims
Sedgwick, Merrion Hall,
Strand Road,
Sandymount, Dublin 4

T: 1800 719 420 or
+353 (0)1 440 1757

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/ie-en/footer/privacy-policy.aspx or by searching 'Master Privacy Policy' on https://www2.chubb.com/ie-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.
Once completed please email to travel@ie.sedgwick.com and include any supporting documentation.

Policy number

Main Policyholder details

Title | **First name** | **Last name**

Email address | **Date of Birth (DD/MM/YY)**

Full address

Postcode

Contact no. (day) | **Contact no. (eve)**

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
			☐
			☐
			☐
			☐
			☐

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:

Explicit Consent to use Health Information- Important Please Read

We carefully assess your claim, and also take steps, in common with standard industry practice, to monitor for fraudulent claims. For these reasons, we may need to use information about your health which is relevant to your claim, and, where relevant, the health of other persons relevant to the claim which you provide to us. ***You must ensure that any other persons whose information you provide to us understand and do not object to this use of their data, and (where required under applicable law) consent to us using their information for the purposes described here.***

We will not use this health information for any other purpose, and will comply at all times with the terms (including security standards) referred in our Privacy Policy. You do not have to provide us with the following consent, and you may withdraw it at any time, but if you do not provide it, or choose to later withdraw it, that may affect our ability to process your claim.

Please tick the following box to indicate your consent to our use of your health information in this way. ☐

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: _____

Address: _____

_____

_____

_____

_____

Postcode _____

Bank Sort Code ☐☐ ☐☐ ☐☐

IBAN _____

BIC _____

Account Number _____

Name of Account Holder (s) _____

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.℠