Chubb European Group Limited
Travel Insurance Claims
OSG, Merrion Hall,
Strand Road,
Sandymount, Dublin 4
T: 1800 719 420 or
+353 (0)1 4401757

Claim form

Fatal accident

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 Policyholder details

Title	First name	Last name

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

Full address

	Postcode

Contact no. (day)	Contact no. (eve)

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

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, plese 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:

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)

Data protection

Protecting your privacy is very important to Chubb European Group Limited ("Chubb"). Any information that you or your medical representative provides in the claim form and/or Doctor's Statement is "sensitive data" as defined by the Data Protection Acts of 1988 and 2003. Sensitive data includes any information about your physical and mental health. We require your consent before we can process this or any other such sensitive data that you may have already provided us with or may do so in the future.

In order to administer your claim, this information will be used by Chubb and its group companies. It may be held in computer and or in manual files for administration, and risk assessment purposes. We may disclose your personal data and sensitive data to, and may request information from other insurance companies and private investigators for underwriting, claims handling and fraud prevention purposes.

By returning this form, you consent to our processing your sensitive personal data for the above purposes. You also consent to our transferring your information to countries which do not provide the same level of data protection as Ireland, if necessary for the above purposes. If we do make such a transfer we will, if appropriate put a contract in place to ensure your information is protected. Guidelines for sharing of information in this regard are contained in a Code of Practice on Data Protection for the Insurance Sector which has been approved by the Data Protection Commissioner.

Where you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

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.℠