



Please complete and sign the Form and forward along with the requested documentation to; Keaney Insurance Brokers Ltd, 30 Lower Leeson Street, Dublin 2,

Fórsa Life Assurance Claim Form – 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.

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 of joining Fórsa

Employer:

Workplace address:

Grade/Job category:

Sum Assured: EUR 5,000.00

Death Certificate enclosed

YES NO

Marriage Certificate enclosed if married female (if married name is different from the birth certificate)

YES NO

Other proof of name change enclosed if applicable

YES NO

Evidence of a of joint bank account at the same address or

YES NO

Evidence of a joint mortgage or rental agreement at the same address or

YES NO

A utility bill showing both names at the same address other (please specify)

YES NO

Other evidence showing residence at the same address

YES NO

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:

OSG Group Merrion Hall, Strand Road, Sandymount, Dublin 4 in accordance with the requirements of the Data Protection Act 1998.

Claimant's signature: _____



Declaration

I hereby certify that the foregoing information is true and correct and I agree that any statement made by me and found by OSG Group to be false shall surrender all my rights under my policy at the option of the company.

I hereby authorise any hospital, physician, employer or any other person to furnish all information as requested by the company or its representative in consideration of the claim. In accordance with the Access to Medical Reports Act 1988.

Copies of this declaration will be legally valid.

I understand that this form will be passed to ***or used by member companies of:***

OSG Group Merrion Hall, Strand Road, Sandymount, Dublin 4 for the purpose of this insurance. This includes underwriting, processing, claims handling and fraud prevention, which could include passing details to agents of OSG Group or other insurers. You may ask other insurers for information to check the information I have given.

Claimant's signature:

Full Name:

Full Address (including postcode):

Telephone Nos:

Work:

Mobile:

E-mail:

Date:



Form of Discharge

Term Life Assurance

Deceased Name:

I the undersigned as legally defined and accepted Spouse of the above hereby request XL Catlin Syndicate 3002 , 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 XL Catlin Syndicate 3002 from any further liability whatsoever in respect of this claim.

All benefits will become payable upon receipt of this signed declaration

Signature of Beneficiary:

Title: (Mr/Mrs/Ms/Dr)

Name:

Date:
