KEANEY INSURANCE BROKERS LTD.

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 you joined Fórsa _____

Employer: _____

Workplace address: _____

_____

_____

_____

Grade/Job category: _____

If you were a member of a union prior to 2nd January 2018, please confirm which union:

IMPACT ☐

CPSU ☐

PSEU ☐

KEANEY INSURANCE BROKERS LTD.

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**

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

Name: _____

Address _____

_____

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: _____

KEANEY INSURANCE BROKERS LTD.

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:

KEANEY INSURANCE BROKERS LTD.

Settlement of this claim will be made by electronic transfer

Member's Bank Details:	
Bank Account Name:	_____
Bank Account Number:	_____
Bank Sort Code:	_____
Bank Name:	_____
Bank Address:	_____
	_____
	_____

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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