RISK ASSURANCE MANAGEMENT

GROUP LIFE ASSURANCE: CLAIM FORM

INSTRUCTIONS FOR COMPLETION

1. Please ensure that this claim form is completed in full and that ALL required documentation is attached. Failure to do so may result in delays.
2. Please attach all original documents to this claim form.

Document Checklist **(please tick as appropriate)**

Original Death Certificate or original Coroner's Certificate ☐

Please be aware that on receipt of this claim Risk Assurance Management Limited may need to request additional details from a third party (or parties) in order to validate this claim

We will not meet any claims, or any requests for additional amounts of benefit, submitted to us more than 2 years after the date of a member's death.

The issue of this form is not an admission of liability.

SECTION 1 - Policy Details

Scheme Name:
Policy Number:

SECTION 2 – Deceased's Details

Serving Member ☐ **Spouse/Partner of Serving Member** ☐ **Retired Member** ☐ **Spouse/Partner of Retired Member** ☐ **Child** ☐

Title: (Mr/Mrs/Ms/Other)	
First Name(s):	Surname:
Date of Birth:	Date of Death:

Serving Members Collar/Payroll Number (for all Claims):

Date Serving/Retired Member Joined Force:	Date Deceased Joined Scheme:

Serving/Retired Member's Name (in respect of all Spouse/Child claims):
Serving/Retired Member's Date of Birth (in respect of all Spouse/Child claims):
Retired Member's Retirement Date (in respect of all Retired Member claims):
Serving Member's Last Day Actively at Work (in respect of all Serving Member claims):

Has Terminal Prognosis Advance benefit previously been paid: Yes/No (if yes please state amount and date paid):	Sum Assured (less Terminal Prognosis Advance benefit if applicable):

SECTION 3 - Claims Settlement

We hereby apply to Risk Assurance Management Limited for payment of the sum assured claimed. We declare that the deceased was a Member of the Scheme and paying premiums up to date at the date of death and the particulars provided are correct to our knowledge and belief. We confirm that payment of this claim will be in full and final settlement and will discharge all liability in respect of this Member under this Contract.

Settlement of this claim will be made by electronic transfer to the Policyholder who is:-

The Trustees of the:

Trustees Bank Details:	
Bank Account Name:	……..
Bank Account Number:	……..
Bank Sort Code:	……...
Bank Name:	……..
Bank Address:	……..
	……...

NB: Payments will not be made to any parties other than the Trustees of the Scheme.

Authorised Signature:

Position:

This form must be signed by a duly authorised person on behalf of the Policyholder (e.g. Director, Company Secretary, Trustee)

Print Name:

On Behalf of:

Date: | | | | | | | | | (Day / Month / Year)