CLAIM FORM

Fatal Accident

ACE European Group
Claims Department
PO Box 4511
Dunstable LU6 9QA
tel: 0845 841 0059
fax: 0141 285 2901
e-mail: claims@acegroup.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.

Name of Policyholder	Policy no.
WEST YORKSHIRE POLICE FEDERATION	**UKBOTC43932**

MAIN POLICYHOLDER DETAILS

Title	First name	Last name

Email address	Date of birth (DD/MM/YYYY)

Full address	
	Postcode

Contact no. Daytime	Contact no. Evening

Please complete the information below as we will need this to check your cover with the Federation Office.

☐ **SERVING OFFICER**
RANK
COLLAR/POLICE ID No.
PAY OFFICE

☐ **POLICE STAFF**
STAFF No.
PAY OFFICE

☐ **RETIRED**

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 ACE.

INSURED PERSONS DETAILS

Full name	Date of birth (DD/MM/YYYY)	Relationship to main policyholder	I intend to claim on behalf of: (✓) where applicable
MAIN POLICYHOLDER AS ABOVE			

insured.™

EMPLOYMENT DETAILS

Occupation/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 No. (HOME) _____ Telephone No. (BUSINESS) _____

Email address _____

Please provide a copy of the Insured Persons Itinerary/Travel documents

ACCIDENT DETAILS

Please give exact date and time of accident: 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 HM 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: _____

_____ *Bank*

Address _____

_____

_____

_____ Postcode _____

Bank Sort Code (from the top right hand corner of your cheque)

Account Number _____

Account Name(s) _____

_____

DATA PROTECTION

In order to administer your claim, this information will be used by ACE European Group Limited and its group companies. It may be held on 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 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 the UK, 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.

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.

_____ _____

SIGNED DATE

TO BE COMPLETED AT THE FEDERATION OFFICE Where possible please endorse with official stamp

I certify that the claimant is a member of the Scheme.

USE OFFICIAL STAMP

_____ _____

SIGNED DATE

CHECKLIST

Please return the completed claim form together with any enclosures to Federation Office and please ensure...

- ☐ You have completed **all** relevant questions on this claim form
- ☐ You have enclosed all requested original documents (we recommend you retain copies)
- ☐ You have signed this claim form

As failure to do so will result in delay in handling your claim.

ACE European Group Limited registered in England & Wales number 1112892 with registered office at 100 Leadenhall Street, London EC3A 3BP. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority (FCA) and the Prudential Regulation Authority reference number 202803. Full details can be found at the FCA website www.fsa.gov.uk/register/home.do or by contacting the FCA on 0800 111 6768.