PROOFS OF DEATH SUBMITTED TO

CLAIMANT'S STATEMENT

UNION HERITAGE LIFE ASSURANCE COMPANY DESIGNATED ACTIVITY COMPANY

4th Floor, Block E Iveagh Court
Harcourt Road, Dublin 2

Union Heritage Life Assurance Company dac is regulated by the Central Bank of Ireland.

NOTE: This side is to be completed by the deceased insured's representative and sent, along with the death certificate, to the above address. Be sure to look at the instructions at the top of the form on the reverse side to see if it must also be completed.

Policy Numbers | | | |

INFORMATION ABOUT DECEASED

Deceased's name	Date of death
Deceased's address	Place of death (If hospital or institution, give name)
Deceased's occupation	Cause of death
Deceased's union and branch #/credit union affiliation	Did death result from: Suicide? ☐ Homicide? ☐ Accident? ☐
Deceased's birth date	If answered yes to Homicide or Accident, please forward copies of accident and/or police report. Also enclose any pertinent newspaper articles.
When did deceased first complain or give other indication of last illness?	When did deceased first consult a doctor for last illness?

Give the name and address of doctors who treated deceased during the 5 years prior to death:

Name	Address	Disease or condition	Dates

INFORMATION ABOUT REPRESENTATIVE

Representative's name	Representative's relationship to Insured
Representative's address	Representative's telephone number
	Representative's Personal Public Service Number (PPS)
Is the policy attached? ☐ Yes ☐ No If no, reason not attached:	Representative's birth date
	E-mail address

Any person who knowingly and with intent to injure, defraud or deceive any insurer, submits an application or files a claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a crime.

I authorise and request the hospital/specialist/consultant/doctor/health provider concerned to furnish Union Heritage or its duly authorised agent acting on its behalf (including but not limited to, medical professionals whose services are retained by Union Heritage for the purpose of assessing claims) with all necessary information as Union Heritage or its authorised agents may seek in connection with any treatment or other services provided to the deceased for the purpose of Union Heritage considering this claim. This explicit consent is given within the meaning of the Data Protection Acts 1988 & 2003 (as amended) to sensitive personal information (including hospital/medical records) being collected by Union Heritage or its authorised agent for the purpose of undertaking investigations into and to adjudicate on this claim.

Date _____ Signature of representative _____

PROOFS OF DEATH SUBMITTED TO **DOCTOR'S STATEMENT**

UNION HERITAGE LIFE ASSURANCE COMPANY DESIGNATED ACTIVITY COMPANY

4th Floor, Block E Iveagh Court
Harcourt Road, Dublin 2

Completion of this side of the form is required if the policy (or any rider added to the policy) is less than two years old or if the policy (or any rider added to the policy) has been reinstated within the last two years. If completion is required, please ask the doctor who treated the last illness of the deceased to complete this side of the form before you post it to the Company.

Deceased's name	Date of death

Cause of death *(Enter only one cause for each of a, b, and c.)*

Interval between onset and death

Disease or condition directly leading to death: *(This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)*

(a) _____ (a) _____

Antecedent causes. *(Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)*

Due to (b) _____ (b) _____

Due to (c) _____ (c) _____

Other significant conditions: *(Contributing to the death but not related to the disease or condition causing death.)*

Date of First Attendance in Last Illness	Date of Last Attendance in Last Illness

If death was due to accident, suicide or homicide, specify which. Describe briefly.

Was an inquest held? ☐ Yes ☐ No

Was an autopsy performed? ☐ Yes ☐ No

If so, by whom and with what findings?

Have you treated or advised the deceased during the 5 years prior to last illness? ☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during such 5 years from any other Doctor, or in any Hospital or Institution? ☐ Yes ☐ No

If Yes to either question, please furnish the following:

Name of Doctor or Hospital	Address	Disease or Condition	Dates

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Date _____ Signature of doctor _____

Address _____