

# Excepted Group Life Trust Solution

## Claim form – Employees

This form is to be completed by the policyholder. Please send the completed form to Zurich at the details shown below.

Scheme name:

Scheme number:

### 1 Employer contact details

Employer name:

Main contact name and job title:

Registered address or main place of business:

Email address:

Phone number:

### 2 Death certificate

Did the death occur overseas? (If 'Yes', please complete Section 6)

☐ Yes

☐ No

Was a Coroner's interim certificate issued? (If 'Yes', please send us the certificate as this will not appear in our online registry)

☐ Yes

☐ No

If the death occurred in the UK and a full death certificate has been issued, we may be able to validate the death over the phone, without the need to see the original certificate. Please note, the registry takes two weeks from the date the death is registered to appear online. **If you have answered 'No' to the above questions and 2 weeks have passed, please call our claims team on 0800 181 4004.**

Is the certificate enclosed? ☐ Yes Reason (e.g. Coroner's certificate issued):

☐ No Reason (e.g. to be validated online):

(If provided in the post the original death certificate will be returned by recorded delivery)

### 3 Deceased member's details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other (please give details)

Surname:

Forename(s):

Date of birth:

Postcode:

Date the member joined the employer:

Date included in the scheme:

If there is a difference between the 'Date the member joined the employer' and 'Date included in the scheme', please let us know why below:

Date last actively at work:

Please confirm reason for absence:

☐ Illness/Injury ☐ Redundancy ☐ Holiday ☐ Other Reason:

Date of death:

Cause of death:

## 4 Occupational details

Occupation:

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Location:

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Employee Number:

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## 5 Earnings details

When completing the earnings details, 'policy salary' refers to the salary definition basis agreed between us. This is detailed in your policy schedule for the scheme.

Policy salary at date of death:

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Policy salary at date last actively at work:

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Core/Default benefit multiplier:

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Flex benefit multiplier:

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If Flex benefit multiplier applicable, date of flex choice:

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Total Lump Sum payable:

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## 6 Overseas death

If the death occurred outside of the UK, please complete the below and send us the overseas death certificate, along with any available documentation relating to the death.

**Please note, following our assessment of this, we may require additional information or may request that our Death Abroad Questionnaire is completed.**

Date of departure from UK:

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Intended date of return to the UK:

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Country visited:

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Purpose of visit:

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Name of attending doctor/medical practitioner (If applicable):

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Has the member been repatriated to the UK? (If 'Yes', please send available supporting documentation)

☐ Yes

☐ No

## 7 Representatives – Personal representative administering the estate

Name:

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Relationship to the deceased:

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Address:

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Email address:

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Phone number:

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## 8 Policyholder declaration

- We hereby apply for payment of the benefit(s) payable under the policy on the death of the member.
- We declare that the information given above is correct and that entitlement to the benefit(s) claimed is in accordance with the terms of the policy.
- We confirm that we have provided the appropriate nomination form. ☐

We confirm that we have the authority to pass information to Zurich, which has been obtained in accordance with data protection legislation, including those to obtaining individual consents to processing and we have made the individual(s) aware how their personal information will be used by Zurich.

We understand that the Trustee will contact all parties to carry out an independent investigation into the personal circumstances of the deceased before a determination regarding the settlement of benefits is made.

This form can only be signed by an authorised signatory. Individuals are authorised signatories if they are; an official listed on Companies House for the Trustees/Policyholder or an individual who has signed the Proposal form for the scheme or a designated member of an LLP or where delegated an individual who has authority to act on behalf of the Trustees/Policyholder.

This form must be printed, signed, scanned and returned to us. If you would like to sign the form online using eSignatures, please contact our claims team by email or phone.

Signature:

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Date:

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Print name:

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Capacity:

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## How to contact us

Please send the completed form by email to: [zcr.life.claims@uk.zurich.com](mailto:zcr.life.claims@uk.zurich.com)

Or if you prefer, please send the form via post to: Zurich Corporate Risk, Unity Place, 1 Carfax Close, Swindon, SN1 1AP.

You can call us on: 0800 181 4004

If you have any questions regarding your rights under the Access to Health Records Act or any questions relating to the process of obtaining, assessing or storing medical information, please write to us at Zurich Corporate Risk, Unity Place, 1 Carfax Close, Swindon, SN1 1AP.

### **Zurich Assurance Ltd.**

Registered in England and Wales under company number 02456671.

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