

Death Benefit Claim Form

Please complete all relevant information in **BLOCK CAPITALS** and tick the **relevant boxes**. Throughout this document, the term “insured member” shall refer to the deceased.

Allianz 
Allianz Worldwide Care

Please send this fully completed Claim Form and the additional documents requested, by post to:
Claims Department, Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

If you have any queries, please contact our Helpline:

English: + 353 1 630 1301
German: + 353 1 630 1302
French: + 353 1 630 1303
Spanish: + 353 1 630 1304
Italian: + 353 1 630 1305

Fax: + 353 1 630 1306
Toll-free numbers: www.allianzworldwidecare.com/toll-free-numbers
Email: client.services@allianzworldwidecare.com
Website: www.allianzworldwidecare.com

1 Insured member's details (the deceased)

Policy number

First name

Surname

Date of birth

Address

2 Details of the person completing this form

Mr. Mrs. Ms. Miss Other

First name

Surname

Relationship to the insured member

Address

Telephone number

Fax

Email

3 Details of death

Date of death [d | d] [m | m] [y | y]
Nature and cause of death _____

Please attach the official death certificate to this form.

Was a post mortem conducted? No (If no, please skip to section 3a or 3b)
Yes Date [d | d] [m | m] [y | y]

Name of the hospital where the post mortem was conducted _____
Name of the pathologist _____
Address of the hospital _____

Please attach the post mortem report to this form.

3a For death caused by an accident

Date and time of the accident [d | d] [m | m] [y | y] Time [h | h] [m | m]
Place of the accident _____
Nature, cause and details of the accident _____

On what date did the insured member first receive medical attention? [d | d] [m | m] [y | y]
Name of the hospital/clinic where the insured member first received medical attention after the accident _____

Name of the treating doctor _____
Address of the hospital/clinic _____

Was the accident reported to the police? Yes No
If no, please give the reason why it was not reported _____

If yes, please give the address of the police station _____

Date the accident was reported [d | d] [m | m] [y | y]
Was the insured member under the influence of intoxicants or drugs in the 24 hours before the accident? Yes No
If yes, please give details _____

Please attach any official accident reports to this form.

3b For death caused by sickness

On what date were the symptoms of sickness first apparent? [d | d] [m | m] [y | y]
Did the insured member suffer from this condition previously? Yes No
If yes, please provide details _____

On what date did the insured member first receive medical attention for this sickness? [d | d] [m | m] [y | y]
Name and address of the insured member's family doctor _____

5 Payment details

Following approval of the claim by Allianz Worldwide Care, payment will be made to the appropriate person(s). Please provide payment details below. **If we decide that the benefit payment is due to more than one person, the details provided below should be for the person you have nominated to receive payment on behalf of the relevant parties.**

Preferred payment method Cheque* Bank transfer**

*Name and address (for payment by cheque)

**For bank transfer, please provide bank details below.

Name of bank account holder as it appears on beneficiary's bank statement e.g. John Smith

Please specify the currency you would like to be reimbursed in (and ensure that your bank account supports the currency chosen)

If your bank is **within the EU**, please supply **both** your IBAN and BIC/Swift code to guarantee the payment of your claim. If your bank is **outside the EU**, IBAN is not required.

Account number

IBAN (EU only)

Sort/branch code

BIC/Swift code

Name of bank

Bank address

6 Authorisation of claimant(s) and release of medical records

I/we certify that to the best of my/our knowledge, this Claim Form does not contain any false, misleading or incomplete information. I/we understand that in the event that this claim is found to be fraudulent in whole or in part, I/we will be liable for prosecution. I/we hereby authorise any general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Allianz Worldwide Care or its appointed representatives. I/we understand that Allianz Worldwide Care reserves the right to request further information or documents necessary to process this claim and undertake to furnish such information or records at my/our own expense.

Signature of claimant Date

Print your name

Signature of claimant Date

Print your name

Signature of claimant Date

Print your name

Signature of claimant Date

Print your name

If more space is needed, please use another Claim Form.

If a parent/guardian is signing on behalf of someone unable to sign for themselves, please provide below the name of the dependant and their relationship to the insured member.

Sections 7 and 8 should be completed by the treating doctor in the case of death by sickness only. Allianz Worldwide Care will not be responsible for any fee incurred for completion of sections 7 and 8 by a doctor.

7 Medical provider's details

Name of doctor/specialist _____
 Qualifications/credentials _____
 Registration number of doctor _____
 Name of hospital/clinic _____
 Address _____
 Telephone number _____ COUNTRY CODE — AREA CODE — _____
 Fax _____ COUNTRY CODE — AREA CODE — _____
 Email _____

8 Medical details

Were you the insured member's usual medical attendant? Yes No
 If yes, please give details of the insured member's medical history and of treatment provided for any illness/disease/infirmities

 On what date was the sickness first brought to your attention? [d | d] [m | m] [y | y]
 Diagnosis _____
 Indicate type of condition Acute Chronic Acute episode of chronic
 Please provide full details of the symptoms/medical condition requiring treatment, including ICD code/DSM-IV

 Had the insured member suffered from this condition previously? Yes No
 If yes, when? [d | d] [m | m] [y | y]
 On what date would the first onset of symptoms have been apparent to the insured member? [d | d] [m | m] [y | y]
 Are you aware of any treatment given for this or any related illness in the past? Yes No
 If yes, please provide details _____

 Did the insured member suffer from any long term or chronic disability? Yes No
 If yes, please provide details _____

 Did the insured member suffer from Acquired Immune Deficiency Syndrom (AIDS), AIDS Related Complex (ARC) or Human Immuno-deficiency Virus (HIV)? Yes No
 If yes, please provide details of whether AIDS, ARC or HIV or any associated complication was a factor causing the death of the insured member

 Was the insured member under the influence of intoxicants or drugs within the 24 hours before the death? Yes No
 If yes, please give details _____

Signature of the doctor _____
 Date of completion by the doctor [d | d] [m | m] [y | y]

Official stamp of the doctor

- Important - please check the following:**
- The form has been completed in full and section 6 has been signed and dated.
 - The death certificate is attached.
 - The diagnosis has been confirmed and is stated on the Claim Form (if applicable).
 - The medical report is attached (if applicable).
 - The post-mortem report is attached (if applicable).
 - The accident report is attached (if applicable).
 - Official documentation proving the insured member's family status is attached.
 - Surviving relative's proof of identity and proof of relationship to the insured member is attached.