

CLAIM FORM

In this form, Scottish Widows plc has been referred to as "the Company".

Please note that the issue of this Form is not an admission of liability

1a) Policy Number:

1b) Life Assured:

1c) Date of Death:

2a) Full name of Claimant(s) (Block Letters): _____

2b) Present Address : _____

Telephone Number: _____

2c) Capacity of Claimant: _____
(e.g Trustee, Executor, Policyholder, Assignee, etc)

3 Payment Details

3a) Details of Payee (for proceeds of cheque): _____

3b) Address where payment should be sent: _____

3c) Please enter any reference: _____

3d) Details of Bank account to be credited: _____
Please credit my/our bank/building society account below:

Bank/Building Society: _____

Sort Code (6 Numbers): _____

Account Number: _____

Account held in the name(s) of: _____

Building Society Reference (if applicable): _____

Please note that when a cheque or direct credit payment reaches your bank/building society, it will take a minimum of 3 days to clear and allow you access to the money.

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Declaration

I/We hereby claim the life assurance benefit and I/We certify that the statements in this form are true and complete.

I/We authorise and request the Company to make payment of the claim by crossed cheque in favour of the Payee and that the crossed cheque is sent by post to the address stated.

I/We consent to the Company seeking medical information from any doctor who at any time has attended the Life Assured concerning anything which affected his/her physical or mental health.

I/We agree that any payment made by the Company shall be in full and final settlement of any claims which I/We can or may have under the policy/ies.

I/We agree that I/We will be responsible for any losses and/or expenses incurred by the Company in consequence of such payment which are the result, and which a reasonable person would consider to be the probable result, of any untrue, misleading or inaccurate information given by me/us. In such circumstances, I/We promise that, on request by the Company, I/We will reimburse the Company the value of the losses and/or expenses incurred by it

**PLEASE INDICATE IF THE FOLLOWING ARE APPLICABLE
(Indicate by ticking the relevant box)**

4a) The Original Policy Document cannot be found

Indemnity and Declaration for missing policy documents (applicable if the above box is ticked)

I/We declare that the original policy documents, for the above numbered policy has been lost, mislaid or destroyed and although searches have been made, it had not been traced.

To the best of my/our knowledge it has not been assigned, mortgaged, settled, deposited, charged or otherwise dealt with in a way which affects its title.(other than already advised). I further declare that I am / we are legally entitled to the policy and will forward it to the Company for cancellation should it be found.

I/We request that payment be made under the above policy even although the policy document has been lost. In return, I/we promise that, on request by the Company, I/we will reimburse the Company part or all of the value of the payment, if the Company later reasonably determines that I/we had no legal or beneficial right to request or accept part or all of the payment.

4b) It is not intended to apply for a Grant of Representation

I/We request that payment be made by the Company to me/us under the above policy without production of a Grant of Representation. In return, I/we promise that, on request by the Company, I/we will reimburse the Company part or all of the value of the payment, if the Company later reasonably determines that I/we had no legal or beneficial right to request or accept part or all of the payment.

4c) Did the Deceased leave a valid Will?

 Y/N

(If Yes, please forward a Certified Copy of the original)

(The next-of-kin should sign below where there is not a Will: the Executors where a valid Will exists. Please note the Company reserves the right to insist on sight of a Grant of Representation if it is deemed necessary).

Signed: _____
(First Claimant)

Date: _____

Signed: _____
(Second Claimant – if applicable)

Date: _____

Signed: _____
(Third Claimant – if applicable)

Date: _____