

Monument Claim Form

Planholder:

Plan number:

Deceased life insured's details

Title (please tick)	Mr		Mrs		Miss		Ms		Other	
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Surname	
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Forename(s)	
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Date of birth	
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Was the death a result of an accident? (If yes, please give details)	
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Death certificate

(We need the original death certificate before payment can be made, this will be returned immediately).

Is the original death certificate enclosed?	Yes		No	
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If it is not enclosed, why?	
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Claimant details

Claimant one

Title (please tick)	Mr		Mrs		Miss		Ms		Other	
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Surname	
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Forename(s)	
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Claimant two

Title (please tick)	Mr		Mrs		Miss		Ms		Other	
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Surname	
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Forename(s)	
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Claimant three

Title (please tick)	Mr		Mrs		Miss		Ms		Other	
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Surname	
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Forename(s)	
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Claimant four

Title (please tick)	Mr		Mrs		Miss		Ms		Other	
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Surname	
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Forename(s)	
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Claimant bank details

Name of bank	
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Bank address	
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Account name	
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Account number									
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Sort code					
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Claimant declaration

- I/We hereby apply for payment of the benefit(s) payable under the plan on the death of the life assured.
- I/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 plan.
- Payment by you in accordance with this request shall be a full and sufficient discharge of your liability under this plan.

Signature	<input type="text"/>	Print name	<input type="text"/>
Date	<input type="text"/>	Capacity	<input type="text"/>

Signature	<input type="text"/>	Print name	<input type="text"/>
Date	<input type="text"/>	Capacity	<input type="text"/>

Signature	<input type="text"/>	Print name	<input type="text"/>
Date	<input type="text"/>	Capacity	<input type="text"/>

Signature	<input type="text"/>	Print name	<input type="text"/>
Date	<input type="text"/>	Capacity	<input type="text"/>

Witnessed by

Title (please tick)	Mr		Mrs		Miss		Ms		Other	
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Surname	
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Forename(s)	
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Address	
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Signature

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Date

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Capacity

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