

# BMW Death Registration Claim Form



## IMPORTANT INFORMATION WHEN MAKING A CLAIM

Incomplete claim forms may cause delay in the assessment of your claim.

**The Life Cover is underwritten by Allianz Life Luxembourg s.a. Registered Office: 14 Boulevard Fr. Roosevelt, L-2450 Luxembourg. In accordance with the provisions of European directive 2002/83 of November 5th 2002, the authority in charge of the control of the contracts is the “commissariat aux assurances” of the Grand-Duchy of Luxembourg – 7 Boulevard Royal – L2449 Luxembourg.**

**This insurance product is administrated by Mondial Assistance Limited who are authorised and regulated by the Financial Services Authority (FSA). Mondial Assistance (UK) Limited will act as agent for Allianz with respect to claims process.**

**Please note that all calls are recorded for accuracy and training purposes.**

**We recommend that you send your claim documents by recorded delivery.**

**Return your completed claim forms as soon as possible in order for us to progress your claim as quickly as we can. Return forms to Claims Department, BMW Protect Services, PO Box 1852, Croydon, CR9 1PW.**

**We strongly recommend that you keep copies of your completed claim form and all other supporting documents.**

# BMW Death Registration Claim Form - Please Complete in Block Capitals

## POLICYHOLDER DETAILS (TO BE COMPLETED BY BENEFICIARY)

Policy Number

Title

Last Name  First Name(s)

Address

Post Code

Home Telephone Number

Date of Birth  Date of Death

Name, address and telephone of deceased's usual doctor.

Postcode  Telephone Number

Did the deceased have any other income protection or payment protection insurances?

If yes, please attach name, address and telephone number of insurer and the monthly benefit amount.

## BENEFICIARY DETAILS (TO BE COMPLETED BY BENEFICIARY)

Title  First Name(s)

Last Name

Relationship to Deceased

Address

Post Code

Home Telephone Number

IN ORDER TO PROCESS THE CLAIM PLEASE ATTACH AN ORIGINAL CERTIFIED COPY OF THE DEATH CERTIFICATE.

PLEASE FORWARD WRITTEN CONFIRMATION OF THE BENEFICIARY (IES) BY WAY OF GRANT OF PROBATE OR OTHER LETTERS OF ADMINISTRATION.

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## MEDICAL CONSENT (TO BE COMPLETED BY BENEFICIARY)

### ACCESS TO MEDICAL REPORTS ACT 1988 - EXPLANATION

In order for us to process the claim we may need to obtain medical reports from the policyholders doctor. Before we approach their doctor we need your consent under the Access to Medical Reports Act 1988. Your rights under the Act are as follows:

You do not need to give your consent, however if you do not, we may not be able to consider the policyholders claim. This does not prevent you from applying to other insurance companies.

You can ask to see the report before the doctor returns it to us. If this is the case, we will tell the doctor to keep the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report in this time, the policyholders doctor will send the report to us.

If you choose not to see the report at this stage, you may ask the policyholders doctor for a copy within six months of it being sent to us. We can send a copy of the report to the policyholders doctor if you ask to see it at a later date.

If you believe that any part of the report is not correct or is misleading, you may ask the policyholders doctor to amend it. If the policyholders doctor refuses to make the amendments, you may ask him or her to attach a statement outlining your views, which will accompany the report.

The policyholders doctor can withhold access to the report if he or she feels that it would cause physical or mental harm to you or others.

## CONSENT TO OBTAIN MEDICAL REPORT

Please make sure you have read the above rights before you complete and sign the consent below. I have been informed of my statutory rights under the Access to Medical Reports Act 1988 as explained above and in connection with the insurance claim. I consent to the insurer Allianz Life Luxembourg s.a. working on behalf of BMW Financial Services being provided with medical information, including a copy of the policyholders medical notes and consultant reports from any doctor who at any time has attended the policyholder concerning anything which affected the policyholders physical or mental health, and I agree that a copy of this consent shall have the validity of the original.

I WISH TO SEE THE MEDICAL REPORT, please tick as appropriate

YES

NO

Signed

Date

Please print name