



# Claim Form

## A. Using this form

Some of the terms we use in this form appear in *italics*. These terms, and some others, are explained in the Claim Guide enclosed, which we hope you will find useful.

This form is used to:

- (a) make claims against policies issued by Pearl following the death of a *life assured* or *policyholder*; and
- (b) enable us to gather the information we need to validate, and settle, each claim.

This form should be completed by the *Legal Personal Representative(s)* of the *Deceased's Estate* or one of the following:

- the *Executor(s)* named in the *Will*, where a *Will* was made; or
- the *Administrator(s)* named in the *Grant of Representation*; or
- the *next of kin*; or
- the *Policyholder, trustee* or similar.

The Claim Guide provides further information and will help you determine the identity of the *Legal Personal Representative(s)*.

It is important all sections of this form are completed, and you include as much information as you can. This will help us settle the policy claims as quickly as possible. We may need to seek additional information before we can settle policy claims. If so, we will write out promptly to ask for this information. The information you provide should be that which was applicable at the date of death.

Please complete all sections of this claim form in block capitals.

If you have any questions, or would like help with your claim, please contact us.

## B. Details of the person who has died

Full name:
Date of birth:            /            /
Date of death:            /            /

## C. Policies claimed against

Please list the policies which are being claimed against. If you hold the policy documents, please return them with this form and tick the box to confirm you have enclosed them.

Policy number	Policy document enclosed	
<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you are claiming against more than eight policies, please list the additional policies in Section H of this form, and confirm if you are returning the policy document(s).

## D. Details of claimant(s)

Please provide the details for each claimant and answer the questions by ticking the appropriate boxes.

If you believe that the claimants are different for each policy, please contact us.

If there are more than four claimants, please provide details for the additional claimant(s) in Section H of this form. **All** claimants must sign this original Claim Form.

### Contact details - Claimant 1:

Full name:

Address:

Postcode:

Preferred  
daytime number:

Alternative number:

### Status details - Claimant 1:

(1) In what capacity are you completing this form?

**Executor**       **Administrator**   
**Next of Kin**       **Policyholder**   
**Trustee**       Other

If 'Other', please specify

(2) What is your relationship to the **Deceased**?

### Contact details - Claimant 2:

Full name:

Address:

Postcode:

Preferred  
daytime number:

Alternative number:

### Status details - Claimant 2:

(1) In what capacity are you completing this form?

**Executor**       **Administrator**   
**Next of Kin**       **Policyholder**   
**Trustee**       Other

If 'Other', please specify

(2) What is your relationship to the **Deceased**?

### Contact details - Claimant 3:

Full name:

Address:

Postcode:

Preferred  
daytime number:

Alternative number:

### Status details - Claimant 3:

(1) In what capacity are you completing this form?

**Executor**       **Administrator**   
**Next of Kin**       **Policyholder**   
**Trustee**       Other

If 'Other', please specify

(2) What is your relationship to the **Deceased**?

### Contact details - Claimant 4:

Full name:

Address:

Postcode:

Preferred  
daytime number:

Alternative number:

### Status details - Claimant 4:

(1) In what capacity are you completing this form?

**Executor**       **Administrator**   
**Next of Kin**       **Policyholder**   
**Trustee**       Other

If 'Other', please specify

(2) What is your relationship to the **Deceased**?



## E. Deceased's marital status

Please provide the information requested below, and answer the questions by ticking the boxes.

(1) What was the **Deceased's** marital status  
(please tick one box only)?

Single       Co-habiting   
Married       Widowed   
Separated       Divorced   
Registered civil partner

Are the policies being claimed against:

**Life or Investment**   
*Please go to Section F*

**Pension**   
*Please complete this Section*

**Not sure, or both**   
*Please complete this Section*

(2) a) If the **Deceased** was married, or in a registered civil partnership, is their spouse / registered civil partner one of the benefit claimants detailed in section D of this form?

Yes       No

Please provide the spouse's / registered civil partner's details in the spaces below, unless you have already provided this information in section D.

Title and full name:

Address:

  
  

Postcode:

Preferred  
daytime number:

Alternative number:

Date of birth:      /      /

b) If the **Deceased** was not married or in a civil partnership, or was married or in a civil partnership but not living with their spouse or civil partner, and they had a dependant partner or cohabitee, is their partner/cohabitee one of the benefit claimants detailed in section D of this form?

Yes       No

If 'No', please provide the partner's details in the spaces below.

Title and full name:

Address:

  
  

Postcode:

Preferred  
daytime number:

Alternative number:

Date of birth:

                 /      /

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## F. Deceased's Next of kin/dependant details

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Please complete this section for ALL policies

(1) Did the **Deceased** have any children, natural or adopted, or any other **dependants**?

Yes  No

If 'Yes', please provide their details in the spaces below. If a child or **dependant** is under the age of 18 years, please also provide details of one of their legal guardians, and give us the address of that guardian. If a child is over the age of 18 years, please give us their address.

It is important that we are told about all children or **dependants**. If there are more than four children/**dependants**, please provide details for the additional people at Section H of this form.

### Dependant & guardian's details.

Contact details – Child / dependant 1
Full name:
Date of birth:            /            /
Full name of guardian if applicable:
Address:
Postcode:
Dependant's relationship to <b>Deceased</b> :

Contact details – Child / dependant 2
Full name:
Date of birth:            /            /
Full name of guardian if applicable:
Address:
Postcode:
Dependant's relationship to <b>Deceased</b> :

Contact details – Child / dependant 3
Full name:
Date of birth:            /            /
Full name of guardian if applicable:
Address:
Postcode:
Dependant's relationship to <b>Deceased</b> :

Contact details – Child / dependant 4
Full name:
Date of birth:            /            /
Full name of guardian if applicable:
Address:
Postcode:
Dependant's relationship to <b>Deceased</b> :



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## I. Claimant's declaration

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All claimants must sign and date this declaration. Please read it carefully before signing.

I hereby declare:

- I will, upon request from Pearl, apply to the Probate Registry of the High Court or Sheriff's Court for a **Grant of Representation**, if one has not already been obtained, if I am eligible to make such an application. I understand that I must meet the costs of obtaining the **Grant of Representation**.
- The information provided in this Claim Form, and in any other documents associated with this claim, is correct and complete.
- Where there is more than one claimant, we agree for all payments due to claimants or other beneficiaries to be made in accordance with the instructions in Section D of this Claim Form.
- I understand, and agree, that on payment of the **Deceased's** policy proceeds I shall have no further financial claims against Pearl.
- If any dispute arises as to the entitlement to the proceeds of any of the **Deceased's** policies, or if a valid claim against one or more of those policies is made by another party, I will repay to Pearl some or all of the amount I have received as a result of this claim, upon request from Pearl.

### Claimant 1 Signature

Date signed:            /            /

### Claimant 2 Signature

Date signed:            /            /

### Claimant 3 Signature

Date signed:            /            /

### Claimant 4 Signature

Date signed:            /            /

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## J. Returning this form

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You should send this Claim Form together with:

- any separate sheets of paper or photocopies you have used; and
- any other documents requested either in this form, or in our letter.

Please send the documents to:

Pearl,  
Claims Team,  
Lynch Wood Park,  
Lynch Wood,  
Peterborough, PE2 6FY

If you have any questions, or would like help completing your claim, please contact us.