



Terminal Illness Claims Form

Certua Life Limited (Company Registration Number: 16478879) is the insurer of this policy and is a private limited company whose registered address is at 12-18 Theobalds Road, London, England, WC1X 8PL. Certua Life Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority (Firm Reference Number: 1043718). This policy is distributed by Certua Life Limited trading as Surely.

Terminal Illness Claim Form

We understand that this is a difficult time for you and we are on hand to support you and make this process as frictionless as possible. If you need any help completing this form, please get in touch.

Need help? Call us on 0808 178 5679 (Monday–Friday, 9am–5pm) or email us at claims@surelylife.co.uk.

Returning this form

Once completed, please send this form and your documents to us by:

Email: claims@surelylife.co.uk

Post: Claims Department, Surely, 12-18 Theobalds Road, London WC1X 8PL

Online: You can also complete this online at www.surelylife.co.uk/claims

Are you completing this form for yourself? ☐ Yes ☐ No

Are you completing this on behalf of someone else? ☐ Yes ☐ No

Your Privacy

We need to collect and use personal information to process this claim.

Here's what you should know:

What we collect: Contact details, medical information about the policyholder's condition, bank details for payment, and information from doctors and consultants. If someone is completing this form on behalf of the policyholder, we also collect their contact details and proof of identity or legal authority.

Why we need it: To verify the claim, assess whether the condition meets the policy definition of Terminal Illness, confirm identity, prevent fraud, and make payment.

Who we share it with: Our reinsurers, medical professionals, our Chief Medical Officer, fraud prevention agencies, and other insurers where relevant to the claim.

How long we keep it: We retain claim records for 7 years after the claim is settled, as required for regulatory and legal purposes.

Your rights: You can request access to your data, ask us to correct it, or request deletion (subject to legal requirements).

For full details, see our Privacy Policy at www.surelylife.co.uk/legal/privacy-policy

Section 1: About the policyholder

Date of birth:

Name:

Policy Number:

Address & Postcode:

Section 2: Third party authorisation

Complete this section only if someone other than the policyholder is filling out this form. If you are the policyholder completing this yourself, skip to Section 3.

Option A: Use this if the policyholder can still sign but needs help completing the form.

☐ I, the policyholder, confirm that I grant consent for this form to be filled out on my behalf by:

Name of person helping: _____

Policyholder's signature: _____

Date: _____

Option B: Use this if you hold Lasting Power of Attorney, are a Court of Protection Deputy, or have other legal authority. Please enclose a copy of the document granting you this authority.

☐ I, _____ confirm that I have legal authority to act on behalf of the policyholder.

Your signature: _____

Date: _____

If you are completing this form on behalf of the policyholder, please complete this section:

Name:

Telephone number:

Email address:

Relationship to the policyholder (*see note 1 at the end of this form*):

Address & Postcode:

Section 3: Your current illness/condition.

What date did you first consult a doctor? (DD / MM / YYYY)

What is the diagnosis?

What were the initial symptoms and when did they start?

What are your current symptoms?

What treatment have you had for this condition?

What future treatment is planned?

Section 4: Other Insurance

Are you insured for any similar benefits with any other company? ☐ Yes ☐ No

Not answering will not prevent your claim being paid but it may help us process your claim more quickly if you do provide this information.

If **Yes**, tell us:

Name of the company:

Policy number:

Benefit (Payout) amount:

Have you submitted a claim to them? ☐ Yes ☐ No

Please confirm you consent for us to contact the insurers you have named above? ☐
Yes ☐ No

Section 5: Bank details

Claims payments can be made to the account from which we collect your premiums, or where necessary to the bank details of a person acting as power of attorney.

Name of account owner:

Sort code: (_ _- _- _)

Account number:

Bank name and address:

Section 6: Medical Contact Details

Please provide the full name, address and contact details of your current GP and any other doctor or specialist consultant who you have consulted in connection with your illness/condition.

GP's name and address:

How long have you been with this GP:

Treating consultant's name and address:

Any other consultant's name and address:

Permission to access your medical records and process your personal information
(see note 2 at the end of this form for your statutory rights)

The insurer will require a report from your doctor, or any medical practitioner you've been seeing, about your health, physical or mental. This may include details of an illness or injury you've suffered.

We need you to give us your permission to obtain this report so that we can provide it to the insurer for you. Your doctor can provide this via post or electronic software.

We will capture your consent for this below. This is a valid way for us to obtain your permission and is legally binding according with UK law. If you do not give us your consent, then we may not be able to fully assess your claim.

Your options (please choose one):

☐ You consent to our application for a report and **do not** wish to see a copy before it is supplied to us (you can always ask your doctor for a copy at another time)

☐ You consent to our application but you **do** wish to see a copy of the report before it is supplied to us.

- Your doctor will be aware that you have chosen this option but you must contact them to see it within 21 days of us sending our application to them. If they have not heard from you within 21 days, they will assume that you do not wish to see it and they will send the report to us.
- If you do see the report, you have the right to request that your doctor amends the report if you believe anything to be incorrect or misleading. If your doctor is unwilling to make these changes, you may:
 - Withdraw your consent
 - Ask for a statement setting out your views to be attached
 - Or, agree to the report being issued unchanged
- Your doctor can withhold elements of the report that they believe may cause serious harm to your physical or mental health, or that of others. Your doctor will not show you information about other people without your permission

☐ You **refuse** to give your consent to us to apply for a report from your doctor.

Section 7: Declarations

By signing the declaration, you confirm your acceptance of the statements contained therein. This form can **only** be signed by the policyholder or a person acting on behalf of the policyholder, either with their permission or acting with power of attorney.

In signing this form, I declare:

- To the best of my knowledge and belief, the information provided in this form is correct, and I authorise payment to be made to the above payee.
- I agree that any payment made shall be in full and final settlement of my claim on the policies numbered above.
- I understand that making a false claim, or supplying false information, could result in my claim not being paid and leave me liable to legal action.

- I give permission for Surely to obtain any health records in respect to the policyholder and for the party named in Section 6 to release or share all health records and related information reasonably requested by Surely for the purposes of administration and assessment of the claim.
- I consent and permit Surely to obtain any health records and related information from other insurers concerning any other claim(s) under similar insurance cover held.
- I consent to the other insurers providing the relevant information to Surely and to Surely sharing health records and related information relating to this claim with the other insurers and reinsurers.

Policyholder's full name (or person with authority):

Date:

Signature:

Enclosures checklist

Please tick to confirm you have enclosed the following documents. If you don't have all documents right now, send what you have, we'll let you know if we need anything else.

Proof of Identity

If you are not the policyholder and you are completing this form, we need to prove your identity as well as the policyholder.

Either

- | | |
|---------------------------------------|--------------------------|
| a) Copy of passport | ☐ |
| b) Copy of photo card driving licence | ☐ |

Medical evidence

- | | |
|--|--------------------------|
| Copy of any medical letters relating to your diagnosis | ☐ |
| Trust or Deed of assignment (if applicable) | ☐ |
| Original Trust deed (if written under trust) | ☐ |
| Copy deed of assignment (if assigned) | ☐ |

Notes

1. In order to complete this form for a policyholder where they have capacity to sign section 2 above, then you must be their next of kin. If the policyholder does not have capacity to sign section 2, then you must have power of attorney and be able to provide us with proof of this power of attorney.
2. Your statutory rights under access to medical reports law: UK and Isle of Man law sets out how medical reports for insurance purposes can be obtained from a doctor, who has been or is looking after you. In England Wales and Scotland, your statutory rights are set out in the Access to Medical Reports Act 1988; in Northern Ireland in the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991; and in the Isle of Man in the Access to Health Records and Reports Act 1993. Your three options (your rights) are outlined in detail in the medical records sections above.