



Financial Insurance Company Limited
Financial Assurance Company Limited
(each part of AXA)
P.O. Box 602, Shannon, Co. Clare

Your Declaration

Please complete and sign this consent form in order for us to process your claim.

Claimant Information

Claimant's Name:	
Claimant's Address:	
Date of Birth:	

Your Declaration

I have become eligible to make a claim under the terms of my policy and receive benefit accordingly. I declare that, to the best of my knowledge, the answers I have given are true and I know that if I knowingly give incorrect information, I will have to repay any benefit I have been paid. I also know that I will lose all rights under my policy and that legal action could be taken against me.

I understand and give explicit consent that the sensitive health and other information I provide about myself will be used by Financial Insurance Company Limited and Financial Assurance Company Limited, their agents and associated companies, other insurers, other regulators, industry and public bodies (including the police) and agencies to process this insurance and any other insurance, handle claims and prevent fraud. This may involve the transfer of such information to other countries (including those outside of the EEA which have limited or no data protection laws). AXA has taken steps to ensure that your information is held securely.

You have the right to access your personal data held by AXA. If you believe that your personal data held by AXA is inaccurate you have the right to ask for this to be rectified. I authorise AXA to make any enquiries and get any information they consider relevant from my doctor, employers or elsewhere.

I understand that I must provide evidence to AXA to prove my claim. I accept that it is my responsibility to disclose all information necessary to the Tax Authorities and to meet any tax liabilities that may arise on claim.

Name (PRINT):	
Signature:	
Date (dd/mm/yy):	