DEATH CLAIM FORM

safrican
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To expedite your claim, kindly forward all claim documentation listed below:

1. Fully completed Death Claim Form
2. Copy of Death Certificate
3. Proof of Identity for the Claimant (Copy of ID / Birth Certificate / Passport)
4. Proof of bank account for the Claimant (cancelled cheque), if proceeds are payable into an account other than the collection account.
5. Fully completed Police Report, if cause of death is unnatural
6. Copy of BI1663 / DHA-1663 or BI1680

Policy number | | | | | | | | | | | | | | |

A. Details of claimant

Full names_____ Surname_____

Where do we send you information?_____

Contact number_____

B. Bank Account details to which Policy Benefits must be paid

Account holder_____ Branch Code_____

Bank name_____ Branch_____

Account number_____ Type of account_____

Declaration

I, the undersigned, hereby acknowledge that I understand the content contained herein and certify that the above information is true and correct in every detail and that Safrican (hereinafter called The Company) is hereby authorised to update and amend my personal details.

_____ Signature of claimant

_____ Y Y Y Y / M M / D D Date

C. Details of deceased

Relationship to deceased ☐ Spouse ☐ Child ☐ Extended Family Member

Where do we send you information?_____

Contact number_____

Cause of death ☐ Natural ☐ Accident ☐ Suicide

If the cause of death is due to suicide / homicide or accident, please ensure that the police report is completed

Death Due to Natural Causes

If death was due to illness, state the reason for the deceased's death._____

D. Declaration by claimant

I hereby notify The Company of the above mentioned claim and confirm that all information given is true and correct. I acknowledge and agree acceptance of this statement and that the supporting documentation shall not constitute or be considered as an admission by The Company that any assurance on the life assured was in fact in force, nor waive the company's rights or defences.

_____ Signature of Life Assured

_____ Y Y Y Y / M M / D D Date

E. Medical report (To be completed by Medical Practitioner)

Medical Practitioner's Details

Full names_____ Surname_____

Practise number_____ Contact number _____

Postal Address / Email Address_____

_____ Postal Code_____

Life Assured Details

Full names_____ Surname_____

Are you the usual medical attendant of the person assured? ☐ Yes ☐ No

If not, please state the name and surname of the usual medical attendant_____

Please state the period of treatment (months and / or years) _____

Name of Doctor _____

Practise number _____ Contact number _____

Postal Address / Email Address_____

_____ Postal Code_____

Names and Addresses of Other Doctors who Treated Patient

Name of Doctor _____

Practise number _____ Contact number _____

Postal Address / Email Address_____

_____ Postal Code_____

Names of Pathology Laboratories and Radiologists Seen

Name of Doctor _____

Practise number _____ Contact number _____

Postal Address / Email Address_____

_____ Postal Code_____

(Please include copies of reports)

Has any other medical practitioner seen the life assured in the past for his/other complaints? ☐ Yes ☐ No

If yes, please state details _____

What treatment / medication were given? _____

Give a Brief Description of the Development of the Illness

When did the symptoms first start? Y Y Y Y / M M / D D

Was the deceased hospitalised prior to his / her death? ☐ Yes ☐ No

Name of the Hospital _____

Practice number _____ Contact number _____

Postal Address / Email Address_____

_____ Postal Code_____

Did the deceased suer from any other associated disease or conditions? ☐ Yes ☐ No

If yes, please state details _____

Was a post mortem examination performed? ☐ Yes ☐ No

If yes, please state details _____

F. Declaration by Employer

Note: The Life Assured / Patient is personally responsible for payment of this report.

I, the undersigned, a registered medical practitioner, certify to the correctness of the information supplied above in respect of the death claim.

_____ Signature of official

Y Y Y Y / M M / D D
Date

Medical Practitioner Stamp

Did employee present a medical certificate to employer? (if yes, copy of medical certificate to be attached) ☐ Yes ☐ No

Nature of Injuries Sustained _____

_____

Contact us

Client Contact Centre:	010 880 5055
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