

GROUP FUNERAL CLAIM FORM



To claim, please complete this form and send it back to us by email, or hand it in at your nearest Safrican Client Services.

Our contact details are:

Physical address Safrican House 21 9th Street Houghton Estate 2198
Email groupclaims@safrikan.co.za
Telephone 010 880 5055

Attach the following documents to the completed claim form:

1. Proof of identity for the claimant (copy of ID or copy of birth certificate or copy of passport)
2. Proof of identity for the deceased (copy of ID or copy of birth certificate or copy of passport)
3. Proof of banking details only if proceeds are to be transferred to an account different from premium collection account
4. Copy of death certificate of the deceased
5. Fully completed police report, if the cause of death is unnatural; accidental; or suicide
6. Copy of BI-1663 or DHA-1663 or BI-1680

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|--------------------------|
| Scheme Name _____ |
| Group Name _____ |

| A. Details of claimant | | Policy Number |
|------------------------------------|----------------------|---------------|
| Full names _____ | Surname _____ | |
| ID/ Passport number _____ | Date of birth _____ | |
| Deceased Name & Surname _____ | | |
| Relationship to the deceased _____ | Contact number _____ | |
| Email _____ | | |
| Physical Address _____ | Code _____ | |

| B. Bank Account details to which Policy Benefits must be paid | | | |
|---|----------------------------------|---------------------------------|---------------------------------------|
| Name of account holder _____ | | | |
| Bank name _____ | Branch name _____ | | |
| Account number _____ | Branch code _____ | | |
| Account type | <input type="checkbox"/> Savings | <input type="checkbox"/> Cheque | <input type="checkbox"/> Transmission |

| C. Declaration by claimant | |
|--|---------------------------|
| Should any benefits be payable to me, I, the undersigned, authorise Safrican Limited to pay the benefits into the above account, and release Safrican Limited from any responsibility and/or further claims from this policy, if payment is made into an incorrect bank account that I gave. | |
| _____ | _____ Y Y Y Y / M M / D D |
| Signature of Life Assured | Date |