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Claim Form – Funeral

To be completed by the claimant

Section A: Policy holder details

Policy number: _____

Full names:_____

Surname:_____

ID number:_____

Physical address:_____

_____

Postal address:_____

_____

Email address:_____

Landline number:_____

Cell phone number: _____

Section B: Claiments details

First name: _____

Surname: _____

ID number: _____

Relationship to deceased:_____

Email address: _____

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Cell phone number: _____

Landline number: _____

Section C: Details of deceased

First names: _____

Surname: _____

ID number:_____

Physical address:_____

_____

Date of death: _____

Cause of death:_____

Section D: Payment instructions

Account Holders name:_____

Name of bank:_____

Name of branch:_____

Branch code:_____ Account Number:_____

Type of Account: Current:_____Savings: _____

Section E: supporting documentation required

The following documents must be submitted with the claim form:

1. Certified copy of death certificate.
2. Certified copy of insured person's ID
3. Certified copy of the beneficiary's ID
4. Completed funeral claim form
5. DHA1663 – notification of death register

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6. Claimant/Beneficiary 1 month bank statement
7. Police report if unnatural death
8. Indemnity form if payment is be made to a third party or any other person except for the main member or nominated beneficiary.

Further information may be requested at our discretion.

DECLARATION

I ,the claimant hereby notify Rand Mutual Life of the death of the life insured and declare that the above answers and full statements are true to the best of my knowledge and belief and that I have withheld no material fact from the company.

I declare that the information given is true and complete to the best of my knowledge and belief and authorise any hospital, physician or other person who has attended to the patient to furnish Rand Mutual Life, or persons acting on behalf of Rand Mutual Life, any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital records, including the results of all tests undergone by the patient. I agree that a photocopy of this authorisation shall be considered as effective and as valid as the original.

Claimant Name:_____

Claimant Signature:_____

Date:_____