

CLAIM FORM – Life

To be completed by the claimant

Policy holder details

Policy number: _____

Full names: _____

Surname: _____

ID number: _____

Relationship to the life insured: _____

Physical address: _____

Postal address: _____

Email address: _____

Landline number: _____

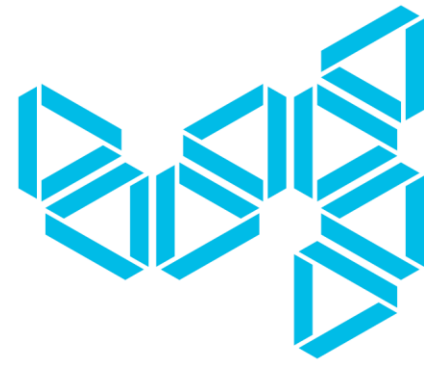
Cell phone number: _____

Details of the Life insured

Date of death: _____

Cause of death: _____

Name of employer at date of death: _____



Address of employer: _____

Telephone number of employer: _____

Occupation at time of death: _____

Previous occupation: _____

Medical practitioner and medical aid details

Name and address of the deceased's usual family doctor (if known): _____

Name and address of all doctors who attended to the deceased during the last five years preceding his death (if known):

Date of illness/injury	Duration of illness/injury	Nature of illness/injury	Doctor or institution	Telephone No.

a) Name of deceased's medical aid society at the time of death: _____

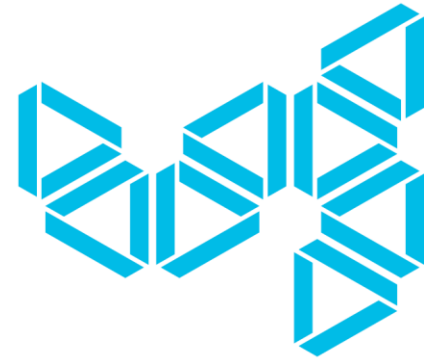
b) Medical aid membership number: _____

Did the deceased have insurance with any other company? Please give details.

Name of Company	Insured Amount	Policy Inception Date



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Was the estate of the deceased insolvent at the time of death? _____

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 medical report

If the insured person dies within the first 2 years of the policy, extra documentation may be needed, such as:

1. Police report / statement completed by the police
2. Copy of the post-mortem report and result of any forensic laboratory investigations
3. Inquest findings or full verdict in the case of a murder (if appropriate) 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 Financial Services, 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.

Title: _____ First names: _____

Surname: _____

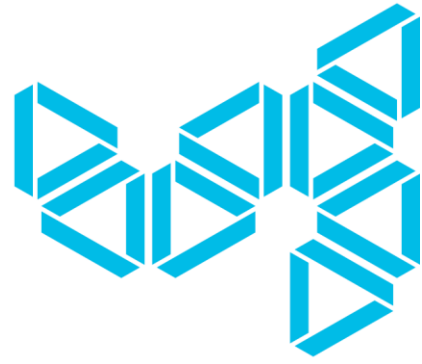
Account Holders name: _____

Name of bank: _____

Name of branch: _____



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Branch code: _____ Account Number: _____

Type of Account: Current: ___ Savings: _____

Signature _____ Date: _____