

Email completed & signed documents to:

claims@simply.co.za

Or post to:

Simply Financial Services

3rd Floor, Grove Exchange

9 Grove Avenue, Claremont 7945

Form in support of Terminal Illness Accelerator Claim on Simply Life benefit

To be completed by the claimant

POLICYHOLDER DETAILS

Policy number: ID number:

Full names:

Surname:

CLAIMANT DETAILS/LIFE INSURED DETAILS

Full names:

Surname:

Date of birth: ID number:

Physical address:

.....

Postal address:

.....

Email address:

Landline: Cellphone:

CLAIM DETAILS

What is the diagnosis/reason for claiming:

.....

When was the condition diagnosed:



Simply Financial Services (Pty) Ltd is
a registered financial services provider
(FSP 47146). T&Cs online.



Hollard Life Assurance Company Limited
(Reg No. 1993/001405/06), a Licensed Life Insurer
and an authorised Financial Services Provider



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MEDICAL PRACTITIONER AND MEDICAL AID DETAILS

Name and address of the insured life's usual family doctor:

.....

Name and address of all doctors who attended to the insured life during the last five years:

.....

Date of illness or injury	Duration of illness or injury	Nature of illness or injury	Doctor or institution	Telephone number

Name of insured life's medical aid society:

Membership number:

Does the insured life have insurance with any other company? Please give details:

Name of Company	Insured Amount	Policy Inception Date

SUPPORTING DOCUMENTATION REQUIRED

The following documents must be submitted with the claim form:

- ☐ Certified copy of insured person's ID
- ☐ Certified copy of beneficiary's ID

- ☐ Certified medical report/claim form with supporting test results



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Further information may be requested at our discretion.

DECLARATION

I, the claimant hereby notify Simply Financial Services of the terminal illness diagnosis of the life assured 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 Simply Financial Services, or persons acting on behalf of Simply, 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.

I understand that this terminal illness benefit is an accelerator to the life cover policy held and that it is approved at the discretion of Simply if the policy terms are met. If it is paid, it reduces the life cover by the claim value paid out.

Title:

First names:

Surname:

Account holder's name:

Name of bank: Name of branch:

Branch code: Account number:

Type of account (current/savings):

Signature: Date:



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