FAMILY FUNERAL CLAIM FORM

Please send completed and signed documents to us at:
Email: claims@oldmutualstaffcover.co.za
Post: Simply Financial Services (Pty) Ltd, Grove Exchange, 9 Grove Ave, Claremont, Cape Town, 7708

IMPORTANT NOTES:

1. This is the claim form for the **family funeral cover only**. If you want to claim on the deceased's life policy, please use the life cover claim form.
2. This claim form must be completed by the person making the claim

POLICYHOLDER DETAILS

Old Mutual SME StaffCover Policy Number:

Name of the organisation (employer):

Registration number of the organisation:

MAIN MEMBER'S DETAILS

First names:

Surname:

ID No:

Physical address:

Postal address:

Email address:

Landline number: Cell phone number:

CLAIMANT'S DETAILS

First names:

Surname:

ID No:

Relationship to the deceased:

Email address:

Landline number: Cell phone number:

DETAILS OF THE DECEASED

First names:

Surname:

ID No:

Physical address:

Date of death: Cause of death:

Place of death (e.g. hospital, clinic, at home):

If at hospital or clinic, please provide the following:

Name of facility:

Address of facility:

Phone number of facility:

Date of funeral: Name of funeral parlour:

Address of funeral parlour:

Phone number of funeral parlour:

Name of doctor that certified the death:

Address of doctor:

Phone number of doctor:

CLAIM PAYMENT INSTRUCTIONS

Account holders namer:

Name of bank: Name of branch:

Branch code: Account number:

Type of Account: **CURRENT:** **SAVINGS:**

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 family funeral claim form
5. DHA1663 – notification of death register
6. Claimant/Beneficiary bank statement (one month)
7. Police report if unnatural death

We may request more information from the claimant if necessary.

DECLARATION

I, Name Surname

the claimant hereby notify Old Mutual Alternative Risk Transfer Limited (OMART) of the death of the life insured person named in this form. I declare that the above answers and statements are true to the best of my knowledge and that I have withheld no material information from the company.

I declare that the information given is true and complete to the best of my knowledge and belief and I give permission for any hospital, physician or other person who has attended to the patient to provide OMART, or anyone acting on its behalf, any information they require concerning this claim. This includes any records of 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 is as effective and as valid as the original document.

Claimant Name

Claimant Signature

Date