CLAIM LIFE COVER 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 **life cover benefit only**. If you want to claim on the family benefit policy, please use the family benefit claim form.
2. This claim form must be completed by the person making the claim

POLICYHOLDER DETAILS (The employer is the policyholder)

Policy Number:

Name of the organisation (employer):

Registration number of the organisation:

CLAIMANT DETAILS

First names:

Surname:

Date of birth: ID No:

Relationship to the person insured:

Physical address:

Postal address:

Email address:

Landline number: Cell phone number:

Are you listed as a beneficiary under this policy? **YES:** **NO:**

DETAILS OF THE LIFE INSURED

Date of death: Cause of death:

Name of employer at date of death:

Address of employer:

Occupation at time of death:

Telephone number of employer:

NATURAL DEATH (complete this section if the life insured died due to an illness)

Date of funeral: Name of funeral parlour:

a) When did the health of the deceased first begin to be affected? (if known):

b) When did the deceased first consult a doctor for his/her illness? (if known):

c) Did the deceased use tobacco in any form? YES: NO:

d) Did the deceased consume alcohol? YES: NO:

UNNATURAL DEATH (complete this section if the life insured died due to an accident and NOT from natural causes)

a) When did the event/accident happen? Date (DDMMYY) and Time:

b) Where did the event occur?

c) If a road accident, please supply the address of the police station where the accident was reported and case number:

Police Station address:

Case number:

d) If possible, please give full details about the injuries sustained by the deceased:

e) Was the death caused by suicide, self-inflicted injury or doing anything against the law? YES: NO:

f) Was the death caused by taking in a war or other hazardous activities? YES: NO:

If yes, please describe the activity that led to the death.

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 before he or she died (if known):

DOCTOR OR INSTITUTION CONSULTED		
NATURE OF ILLNESS/ INJURY		
DATE OF ILLNESS/ INJURY		
DURATION OF ILLNESS/INJURY		
DOCTOR/ MEDICAL 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 life insurance with any other company? Please give details.

NAME OF COMPANY	INSURED AMOUNT	POLICY INCEPTION DATE

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 (deceased) ID
3. Certified copy of the beneficiary's ID
4. Completed medical report

If the insured person died within the first two years of the policy, extra documentation is needed. This includes:

1. Police report / statement completed by the police (if appropriate)
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, Name Surname

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

I hereby authorise any hospital, physician or other person who has attended to the deceased before his/her death to provide OMART, or persons acting on behalf of OMART, with any information regarding 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 deceased. I agree that a photocopy of this authorisation shall be considered as effective and as valid as the original.

Title:		**First names**:	
Surname:			

Signature:		**Date**:	