Death Claim Form

Please return Claim Forms to:
1. **Fax to**
   (011) 351-3003
2. **Post Originals to**:
   Life Claims
   P O Box 87428
   HOUGHTON 2041

TO BE COMPLETED BY THE CLAIMANT

DETAILS OF LIFE ASSURED

Policy number ……………………………………………………………………………

Surname ……………………………………………………………………………

Full names ……………………………………………………………………………...

Date of Birth ……………………………………………………………………………

I.D. number (please submit proof) ……………………………………………………………………………

Residential Address ……………………………………………………………………………

……………………………………………………………………………

……………………………………………………………………………

Postal Address ……………………………………………………………………………

……………………………………………… Postal Code ……………………………

Telephone number (………………)……………………………………………………………...

Name of employer at date of death ……………………………………………………………………………

Address and Tel No of employer ……………………………………………………………………………

………………………………………Telephone Number (…………..)……………………………

Occupation at time of death ……………………………………………………………………………

Previous occupations ……………………………………………………………………………

……………………………………………………………………………..

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DETAILS OF THE DEATH OF THE LIFE ASSURED

Date and time of death ……………………………………………………………………………..

Place of death ……………………………………………………………………………..

Age at death ……………………………………………………………………………

Cause of death ……………………………………………………………………………

1. If this claim arises from illness, please answer this question and ignore question number 2.

   (a) When did the health of the deceased first begin to be affected? ……………………………………………

   (b) When did the deceased first consult a doctor for his/her illness?……………………………………………..

   (c) Did the deceased use tobacco in any form and/or did the deceased consume alcohol? ……………………………

2. If this claim arises from an accident please answer this question and ignore question number 1.

   (a) When did the accident occur? Date (DDMMYY) ……………………………………Time…………………………..

   (b) Where did the accident occur? ……………………………………………………………………………

(c) If a road accident, please supply address of the police station to which the accident was reported and case number

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(d) If possible, please give full details on the nature of the injuries sustained by the deceased

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3. Name and address of the deceased's usual family doctor

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4. Name and address of all doctors who attended to the deceased during the last five years proceeding his death

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

5. Medical aid details

(a) Name of deceased's medical aid society at the time of death ………………………………………………………………………………………………..

(b) Medical aid membership number ………

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

Name of company	Amount	Policy inception date (DDMMYY)

7. Have you any knowledge of any cession or other lien on the contract? If so, please give details.

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8. (a) Have you or the deceased ever been insolvent or made any assignment for the benefit of creditors or are any such proceedings pending or contemplated? If so, please give full details.

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(b) Was the estate of the deceased insolvent at the time of death?

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9. In what capacity or by what title do you claim the insurance benefits?

…….

10. Are you over 18 years of age?……….

DECLARATION

I, ……...the claimant hereby notify HOLLARD LIFE ASSURANCE COMPANY of the death of the life assured and declare that the aforegoing 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 hereby make claim to the benefits of the insurance with HOLLARD LIFE ASSURANCE COMPANY and agree that the written statements and affidavits of all the doctors who attended or treated the deceased and all other papers furnished in support of this claim shall constitute and are hereby made a part of this claim and further agree that the furnishing of this form, or any other forms supplemental hereto, by the company shall not constitute or be considered an admission by it that there was any insurance in force on the life in question or a waiver of any of its rights or defences in law.

I hereby authorise any medical practitioner, hospital or any other person to furnish HOLLARD LIFE ASSURANCE COMPANY, or its representative, any details relating to illness, or injury of the deceased or such information as may be necessary to consider this claim.

Date (DDMMYY)…………………………………………

Signature of claimant……………………………………………

Address of claimant …………….

………………………………………………

…………………..………………………..…

Telephone number (W) (…………….) ………………………….

Telephone number (H) (…………….) …………………………..

Cell No……………………………………………………………

Date (DDMMYY) …………………………………

Signature of witness…………………………………………………….....

Full names and surname of witness: ……………………………………...

Contact number of witness: ………………………………………………

ID number of witness: ……………………………………………………

Address of witness………………………………………………..…………

…………………………………………………………………………….

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