Business Overhead Expenses Benefit Claim Form

Hollard.

(To be completed by life assured)

If you are only claiming for business overhead expenses, the disability forms for medical attendant and claimant need to be completed as well.

Your claim will only be considered if every question has been completed in full.

The following must be included when submitting this form:

a. Proof of all expenses detailed below
b. Audited financial statements
c. Proof of the business bank account details

Return the completed form and the above documents to lifeclaims@hollard.co.za or fax to 086 659 0135.

1. Life assured details

Policy no. ______________________ ID no. ______________________

Full name ______________________

Tel. no. ______________________ Cell no. ______________________

E-mail address ______________________ Mandatory

2. Business details

Name of company ______________________

Business tel. no. ______________________ Fax no. ______________________

Business address ______________________

Postal address ______________________

What is the exact nature of the business? ______________________

How long has the company been in business? ______________________

State share/interest in business ______________________

Statement of expenses for the period being claimed for

Description	**Number**	**Total monthly payroll**
Administration		
Secretarial		
Artisans		
Assistants		
Other		
TOTAL		**R**

Employee details:

Description	**Expense**
Mortgage/rent/lease	
Water	
Electricity	
Telephone	
Maintenance and janitorial services	
Property and liability insurance premium(s)	
Other (specify)	
TOTAL	**R**

Hollard.

3. Accounting details

Full name(s) of accountant/auditor

Under which company name does he/she trade?

Tel. no. ______________________ Fax no. ______________________

E-mail address ______________________ Mandatory

Business address ______________________

Postal address ______________________

4. Declaration by life assured

I am entitled to make a claim on this policy and accept that the proceeds arising from this claim will be payable to:

a. the cessionary on Hollard Life records if the policy has been ceded, otherwise to
b. the policy owner in all other circumstances.

I declare the above details are true and complete. I authorise any doctor or any other person who has attended to the life insured, or any hospital or other institution that has medical information about the life insured or claimant, to disclose such information to Hollard Life.

Full name ______________________

Signature ______________________ **Date** | D | D | M | M | Y | Y | Y | Y |