# Certificate of income received

Hollard.

**(To be completed by claimant)**

Please note that it is essential to complete this form in full to prevent unnecessary delays as a result of missing information.

NB: It is important that this form is completed with details that are accurate, true and in full and that you sign the form, as it constitutes a legal document.
**Return the completed form and the above documents to lifeclaims@hollard.co.za or fax to 086 659 0135.**

## 1. Policy owner details

Policy no. _____ ID no. _____

Full name _____

## 2. Claimant details

Full name _____

ID no. _____

Cell no. _____

Home tel. no. _____ Fax no. _____

E-mail address _____ Mandatory

Physical address _____

Postal address _____

_____

Relationship between claimant and life insured: (e.g. father/son) _____

## 3. Details regarding any income earned

3.1. Have you participated in any form of work for remuneration since Hollard Life started paying your benefit? ☐ Yes ☐ No

If yes, supply details below

| Type of work | From when | To when | Amount paid | How has your illness/injury made it difficult for you to do this work? |
|---|---|---|---|---|
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |

3.2. Have you received payment from any of the following sources?

| | Yes/No | Amount received | Lump sum or monthly payment? | Payment made from (date) | Payment made to (date) |
|---|---|---|---|---|---|
| Workmen's compensation (WCA/COID) | | | | | |
| Unemployment Insurance Fund (UIF) | | | | | |
| Third party claim | | | | | |
| Any other insurance benefit | | | | | |
| Commission | | | | | |
| Other (please specify) | | | | | |



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## 4. Declaration by claimant

I declare that 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.

**Signature** _____ **Date** | D | D | M | M | Y | Y | Y | Y |