

CLAIMS APPLICATION AND DISCHARGE HOLLARD FUNERAL PLAN

Section 1. Validation and Confirmation

I, _____
the claimant on this policy, confirm that I (i) have read, (ii) understand, (iii) agree, and (iv) will adhere to the requirements noted in Section 1. *Should you not agree to any of the noted points, please highlight and circle the specified number. E.g. "i", "ii", "iii" or "iv" and submit a reason signed in the presence of a Commissioner of Oaths.)*

Funeral Claim Yes ☐ No ☐

Other products _____

Legal assistance service Yes ☐ No ☐

Airtime	Please provide an Alternate Pre-paid Cell Phone Number if you have a Full contract package as we are unable to dispense Airtime to those packages.		
Alternate Pre-paid Cell Phone no.		If there is no alternate Pre-paid Cell Phone number, please tick this box	

Section 2. Contract Information

Contract information

Scheme name _____

Policy number _____

Information of the Policyholder

Surname _____

Full names _____

Identity no. _____

Section 3. Information of Deceased

Surname _____

Full names _____

Identity no. _____

Residential address _____

Postal code _____

Postal address of late _____

Postal code _____

Section 4. Information of Employment Prior to Death

Name of employer/
school _____

Telephone no. _____

Fax. no. _____

Address of employer/
school _____ Postal code _____

Section 5. Information on Death of the Insured

Information on death of the Insured

Date of death

D	D	M	M	Y	Y	Y	Y
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Cause of death _____
(Please give full details) _____

Information of funeral parlour that conducted the funeral

Name of funeral parlour _____

Address of parlour _____
_____ Postal code _____

Contact person at
parlour _____

Telephone no. _____ Date of funeral

D	D	M	M	Y	Y	Y	Y
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Section 6. Information of Claimant

Surname _____

Full names _____

Identity no. _____

Residential address of
claimant _____
_____ Postal code _____

Postal address of
claimant _____
_____ Postal code _____

Telephonic and
electronic contact
information Work _____ Cell no. _____
Home _____ Email _____

Relation to deceased _____

Name of employer _____ Occupation _____

Country of residence _____ Source of wealth _____

If the policy contains a continuation option and YOU ARE THE REMAINING SPOUSE ON THE POLICY please indicate if you WOULD LIKE TO CONTINUE WITH THE BENEFITS OF THIS POLICY. PLEASE SELECT YES OR NO and ONE OF OUR CONSULTANTS WILL CONTACT YOU.

Yes

☐

No

☐

Section 7. Information of Tribal Authority

Name of Tribal Chief/Headman

Address of Tribal Chief/Headman

Postal code

Telephone no. of Tribal Chief/
Headman

Section 8. Payment/Electronic Transfer Validation Request

Name of bank

Account no.

Branch name

Branch code

Account type

Account holder's ID no.

Account holder's tel. no.

Signature of bank account holder

Date

D	D	M	M	Y	Y	Y	Y
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Section 9. Consent to gain access to, share and receive information

I, _____ the claimant, hereby notify Holland Life Assurance Company of the death of _____ and state that all the information furnished by me is true and complete.

- A. In the event that this claim or any supporting documents are found to be false and or dishonest, Holland Life reserves the right to proceed with legal action against me or any other parties involved.
- B. It is important for insurance companies to share claims, insurance underwriting and Financial Information in order to enable the fair assessment and underwriting of risks and to reduce the number of cases of insurance fraud.
- C. On my behalf and on the behalf of any person I represent herein, I hereby consent to the sharing of private insurance underwriting, financial claims and medical condition information and/or records.
- D. The information provided in respect of the claim and policy may be verified against other sources of information or databases.
- E. I hereby irrevocably authorize any Medical Practitioner, hospital or any other person to disclose and/or hand over to Holland Life, or its representatives, any details, records and/or documents relating to treatment and/or illness, injury or general information relevant to the claim or such information as may be necessary or required to consider this claim.
- F. Holland cares about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this form. We will treat this information with caution and we have put reasonable security measures in place to protect it.

Section 9. Consent to gain access to, share and receive information (cont.)

- G. In accordance with applicable anti-money laundering laws in South Africa, we are required to obtain specific information and evidence to verify your identity (and in many cases the identities of related persons, such as directors, beneficial owners and persons instructing us on your behalf (where applicable)) when applying for cover and on an on-going basis. If we ask you for information or documents (including originals or certified copies) you must provide them to us as soon as possible. If we do not receive adequate information and evidence within a reasonable time of our request we may be unable to provide you with cover or may cancel the policy in accordance with applicable law.

Signature of Claimant

Date

D	D	M	M	Y	Y	Y	Y
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Witness: Name and surname _____

Identity no. _____

Work tel. no. _____

Cell no. _____

Signature of Witness

Date

D	D	M	M	Y	Y	Y	Y
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