



Hollard Accident & Health
 PO Box 1112
 Houghton
 2041
 Telephone 0861 327 222
 Fax 086 616 2608

CLAIM FORM FOR DEATH BENEFIT

Note:

- The issue of this claim form does not imply an admission of liability by the Company.
- The policyholder is responsible for the payment of any fees in connection with the completion of this form
- Only a fully completed and signed claim form can receive our further attention
- Please attach to this claim form, or forward as soon as they are available, certified copies of the following documents:
 - Identity document of the deceased
 - Identity document of the policyholder
 - Death certificate of the deceased
 - Road Traffic Collision Report (if death was due to a motor vehicle accident)
 - Post Mortem report with Blood Alcohol Test report
 - Inquest report and/or Court Proceeding report
 - Letter of appointment of the Executor of the Estate

General Information

Policy Number Effective Date

Name of Policyholder

Name of Deceased (in full)

Date of Birth Relationship to Policyholder

Name of Person submitting the claim

Postal address

..... Telephone number (daytime)

Name of Deceased's usual doctor

Postal address

Telephone number Fax number

Name and postal addresses of any other medical practitioners who treated the deceased for this injury

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Details of the Accident

The accident occurred at(Place)

on(Date)

at(Time)

Name of Police Station where accident was reported

Postal address

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Describe as fully as you can, how the accident happened

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If it was a motor accident, please attach a copy of the Road Traffic Collision report

DECLARATION

I hereby declare and warrant that the information given in this claim form is in every respect complete and true.

I authorise any medical practitioner, hospital or other person to provide the Hollard Insurance Company with any information they may require relating to the medical history of the deceased and the injury to which this claim relates. I agree that this consent shall remain in force at all times, and that a photo-copy or fax of this declaration shall be accepted as the original.

Signed by the claimant or his/her legal representative

Name (please print) Date