Hollard.

FAX - COMPLETED & SIGNED DOCUMENTS TO (011)351-3003 OR
EMAIL - TO lifeclaimsadmin@hollard.co.za OR
POST ORIGINALS - LIFE CLAIMS – PO Box 87428 – Houghton - 2041

Death Claim Form

Policyholder details

Policy number _____ Reference number _____

Full names _____

Surname _____

Or Company name _____

Policy number _____

Claimant details

Full names _____

Surname _____

Date of birth _____

ID number _____

Details of the Life Assured

Date of death _____

Cause of death _____

_____

When did the condition start that caused the death? _____

_____

Was the death caused by suicide, self-inflicted injury or transgressing any law or as a result thereof? _____

_____

_____

Was the death caused by participating in a war or hazardous activities? _____

Name of employer at date of death _____

Address of employer _____

Telephone number _____

Occupation at time of death _____

Previous occupations _____

(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? _____

_____

(a) When did the accident occur? Date (DDMMYY) and Time _____

_____

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(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 _____

_____

_____

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

_____

Name and address of the deceased's usual family doctor _____

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

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

Medical aid details

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

_____

(b) Medical aid membership number _____

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

Name of company	Amount	Policy inception date (DDMMYY)

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

_____

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. _____

_____

Was the estate of the deceased insolvent at the time of death? _____

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

Are you over 18 years of age? _____

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Banking Details

Account Number _____

Account Holder's name _____

Name of bank _____

Type of account _____

Branch name _____

Branch code _____

Should banking details stated above differ from that of your debit order please submit a bank statement/cancelled cheque with your claim form

DECLARATION

I, ...the claimant hereby notify HOLLARD 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 declare that the information given is true and complete to the best of my knowledge and belief and authorise any hospital, physician or other person who has attended to the patient to furnish Hollard Insurance or representatives any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital records, including the results of all tests undergone by me or the patient. I agree that a photocopy of this authorisation shall be considered as effective and as valid as the original.

Title _____

Full names _____

Surname _____

E-mail address _____

Address _____

_____

Postal code _____

Cell phone number _____

Date: _____ Signed: _____