DEATH WITH EDUCATOR BENEFIT CLAIM FORM

Please return to: Hollard Group Risk, 1st Floor, 34 Melrose Boulevard, Melrose Arch or PO Box 87419, Houghton 2041
Tel: (011) 351 5000. Fax: (011) 351 3262. Email: HGRdeathclaims@hollard.co.za

SECTION A: HOW TO CLAIM

It is essential that this form is fully completed to prevent any unnecessary delays due to missing or incomplete information. This form should be completed by the policyholder. If we ask for an original certified copy of a document we will not accept a certified copy of a previously certified copy.

This form is structured in eight sections:

- Section A: How to claim (informative section)
- Section B: Scheme details
- Section C: Employer's details
- Section D: Deceased's personal details
- Section E: General details
- Section F: Claim details
- Section G: Banking details
- Section H: Educator benefit requirements (if applicable)
- Section I: Declaration

This form covers the following claim types - please select the claim type that has given rise to this claim:

Death of the insured where no educator benefit is required ☐ please complete all sections except section H

Death of the insured where the educator benefit is required ☐ please complete all sections

This fully completed form should be accompanied by the following supporting documentation:

- an original certified copy of the deceased's death certificate
- an original certified copy of the deceased's identity document
- a copy of the deceased's last payslip
- proof of banking details (bank statement or account confirmation letter from bank)
- an original certified copy of beneficiary's identity document (if applicable)
- a copy of the accident report form from the South African Police Service

In addition the following documentation should be provided if Section H is completed:

- an original certified copy of each child's unabridged birth certificate
- a trustee resolution or recent beneficiary nomination form stating the names of the children
- an affidavit stating why a child's surname is different to that of the deceased (if applicable)
- an original certified copy of the adoption certificate (if applicable)
- proof of registration at the relevant institution (if currently attending)
- an original certified copy of the parent's identity document (if nominated caretaker is the surviving parent)
- proof of the nominated guardian (if not the parent)
- an original certified copy of the guardian's identity document (if nominated caretaker is a guardian)
- proof of the trust (if applicable)

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Life.

PRIVACY

We respect the confidentiality of your personal and medical information as well as your privacy. If necessary, we may need to share either your personal or medical information, or both, with third parties. These third parties are other insurance and/or reinsurance companies or service providers that may assist us in assessing risk or servicing you. We impose the same strict confidentiality standards on these third parties as is applied by us. By providing the required personal and medical information and signing this, you hereby confirm that you consent to us processing and sharing your personal and medical information with other third parties. We will treat this information with caution and have put reasonable security measures in place to protect it. The information provided will only be used for its intended purpose and will not be shared with Hollard Group or another organisation for marketing additional products and/or services.

SECTION B: POLICY DETAILS

Employer:

Policyholder:

Policy number:

Membership / Employee number:

SECTION C: EMPLOYER'S DETAILS

Name of company:

Physical address:

Code:

Postal address:

Code:

Contact person:

Job title:

Telephone number:

Fax number:

Email address:

SECTION D: DECEASED'S PERSONAL DETAILS

First names:

Surname:

Identity number:

Date of birth: DDMMYYYY

Gender: M F

SECTION E: GENERAL DETAILS

Month for which the last risk premium was paid: MMYYYY

Was the deceased at work on date of death: Y N

If "No" please give the date when the deceased was last at work and the reason for absence: DDMMYYYY

Salary for the month prior to date of death:

Has the deceased been employed in any territory outside the SADC region? Y N

(SADC region means the Southern African Development Community comprising Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, the Republic of South Africa, Swaziland, Tanzania, Zambia and Zimbabwe)

If "Yes" please provide details, including period of employment:

SECTION F: CLAIM DETAILS

Date of death: DDMMYYYY

Cause of death:

If death is a result of an accident please answer the questions below:

The accident occurred at (place):

On (date): DDMMYYYY At (time): hhmm

Name of Police Station where accident was reported:

The SA Police case number:

Describe fully how the accident happened:

SECTION G: BANKING DETAILS

If the death benefit is underwritten through an approved policy, payment will be made to the policyholder (the Fund) only.

If the death benefit is underwritten through an unapproved policy, payment will be made to the policyholder, or as instructed by the policyholder.

Please select to whom payment must be made: Policyholder ☐ Other ☐

If policyholder, please provide the policyholder's banking details:

Name of account holder:

Name of bank:

Branch:

Branch code:

Account type:

Account number:

If other, please list the beneficiaries below and provide the banking details. Note that payment is only done via EFT (electronic fund transfer) and that no third party payments are allowed – payment will only be made to the beneficiary's bank account.

Name of beneficiary A

Identity number:

Benefit %: Relationship to deceased:

Address:

Code:

Name of bank:

Branch:

Branch code:

Account type:

Account number:

Name of beneficiary B

Identity number:

Benefit %: Relationship to deceased:

Address:

Code:

Name of bank:

Branch:

Branch code:

Account type:

Account number:

Name of beneficiary C

Identity number:

Benefit %: Relationship to deceased:

Address:

Code:

Name of bank:

Branch:

Branch code:

Account type:

Account number:

SECTION H: EDUCATOR BENEFIT REQUIREMENTS (if applicable)

You need to advise us of the details of the nominated caretaker (parent/guardian) and/or trust, as well as details of all the surviving children under the age of 24.

After a death benefit claim has been successfully assessed, an "Educator Benefit Certificate" will be issued to the nominated caretaker (parent/guardian). This certificate will detail the nature of the benefits, the claim requirements and list all eligible children.

Please refer to the group policy document and policy schedule for more information on the nature of the educator benefit.

Who is the nominated caretaker of the surviving children? ☐ Parent ☐ Guardian

Nominated caretaker's details:

First names:

Surname:

Identity number:

Date of birth: DDMMYYYY Gender: M F

Residential address:

Code:

Postal address:

Code:

Home telephone number:

Work telephone number:

Cell phone number:

Email address:

Details of trust (if applicable):

Name of trust:

Name of appointed attorneys:

Contact person:

Physical address:

Code:

Postal address:

Telephone number:

Fax number:

Email address:

Details of the surviving children:

Child:

Identity number:

Date of birth: DDMMYYYY Gender: M F

Is the child currently attending an educational institution? Y N

Current year of studies:

Name of current educational institution:

Child:

Identity number:

Date of birth: DDMMYYYY Gender: M F

Is the child currently attending an educational institution? Y N

Current year of studies:

Name of current educational institution:

Child:

Identity number:

Date of birth: DDMMYYYY Gender: M F

Is the child currently attending an educational institution? Y N

Current year of studies:

Name of current educational institution:

Child:

Identity number:

Date of birth: DDMMYYYY Gender: M F

Is the child currently attending an educational institution? Y N

Current year of studies:

Name of current educational institution:

SECTION I: DECLARATION

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life. In the event that this claim or any supporting claim documentation is found to be fraudulent, Hollard Life reserves the right to proceed with the appropriate action against the claimant.

I authorise Hollard Life to make payment as instructed above and I acknowledge that payment by Hollard Life of the benefits claimed, shall release Hollard Life from all liability in respect of such benefits.

I authorise any medical practitioner, hospital or other person to provide Hollard Life with any information they may require relating to the deceased's medical history and/or injury, which may be necessary for Hollard Life's consideration of the claim.

Signed at on this day of 20

Name and Surname of authorised signatory who warrants his/her authority to sign on behalf of the policyholder:

Please include an electronic signature (if available):

Identity Number of authorised signatory:

Designation of authorised signatory:

Telephone number of authorised signatory:

Email address of authorised signatory:

Hollard is committed to "Creating and securing a better future" and therefore subscribes to an internal Anti-Fraud policy. Please report any suspicious or unethical activity anonymously on 0801 516 170 (toll free) or via email at Hollard@tip-offs.com.