FUNERAL BENEFIT CLAIM FORM

Please return to: Hollard Group Risk, 1st Floor, 34 Melrose Boulevard, Melrose Arch or Postnet Suite 196, Private Bag X1, Melrose Arch, 2076
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. Please complete only one form per deceased. 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 nine sections:

- Section A: How to claim (informative section)
- Section B: Policy details
- Section C: Employer's details
- Section D: Main member's personal details
- Section E: Deceased's personal details
- Section F: General details
- Section G: Claim details
- Section H: Banking and beneficiary details
- Section I: Declaration

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

- an original certified copy of the main member's identity document
- an original certified copy of the deceased's death certificate
- a copy of the completed BI-1663
- an original certified copy of the deceased's identity document
- a copy of the main member's last payslip
- proof of banking details (bank statement or account confirmation letter from bank)
- an original certified copy of the beneficiary's identity document
- a copy of the accident report form from the South African Police Service (if applicable)
- if applicable, proof of the deceased's relationship to the main member, i.e. marriage certificate, birth certificate or affidavit

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 and/or the deceased's 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 and managing the 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 form, you hereby confirm that you consent to us processing and sharing your and/or the deceased's personal and medical information with other third parties. We will treat this information with caution and we 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 within the Hollard Group or another organisation for marketing additional products and/or services to you.

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: MAIN MEMBER'S PERSONAL DETAILS

First names:

Surname:

Identity number:

Date of birth: DDMMYYYY

Gender: M F

SECTION E: DECEASED'S PERSONAL DETAILS

Please complete this section if the deceased is not the main member, but another insured (the main member's spouse, child or parent).

First names:

Surname:

Identity number:

Date of birth:

Gender: M F

Relationship to main member:

SECTION F: GENERAL DETAILS

Month for which the last risk contribution was paid: MMYYYY

Was the main member at work on the date of death? Y N

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

Has the main member 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 G: 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 h

Name of Police Station where accident was reported:

The SA Police case number:

Describe fully how the accident happened:

SECTION H: BANKING DETAILS

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 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 or misrepresented, 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 including accident and police reports, which may be necessary for Hollard Life's consideration of the claim.

I have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information. If I am agreeing to the aforementioned on behalf of someone else, I confirm that I have the necessary approval and/or mandate to do so.

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.