

FUNERAL WITH PAID-UP BENEFITS CLAIM FORM

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 / authorised employer representative.

Please return to: Hollard Group Risk, Florence House, 22 Oxford Road, Parktown 2193 or PO Box 87419, Houghton 2041.
Tel: (011) 351 5000. Email: HGRdeathclaims@hollard.co.za

The request for completion of this form in no way constitutes admission of liability by Hollard Group Risk.

REQUIRED DOCUMENTS

The fully completed form should be accompanied by the documentation listed below. Please indicate whether the relevant documents are attached.

- a copy of the employee's identity document (copy of ID Book / front and back of Smart ID Card).
- a copy of the deceased's death certificate .
- a copy of the deceased's identity document (copy of ID Book / front and back of Smart ID Card).
- a copy of the employee's last payslip.
- proof of banking details (confirmation letter from bank or bank statement)
- a copy of the beneficiary's identity document (copy of ID Book / front and back of Smart ID Card), if applicable.
- a copy of the completed DHA 1663 (notice of death / stillbirth) report.
- a report form from the South African Police Service (in the event of an accident or unnatural death).
- proof of an accepted disability benefit claim by any authorised insurance company, if applicable.
- an original certified copy of the marriage certificate or signed affidavit for a common law spouse.
- a copy of identity document of spouse (copy of ID Book / front and back of Smart ID Card).
- copies of identity documents or birth certificates for all listed children.
- an original certified copy of proof of the relationship of the parent to the main member.
- copies of identity documents of parents (copy of ID Book / front and back of Smart ID Card).
- an original certified copy of proof of the relationship of the deceased to the main member (marriage certificate, birth certificate or affidavit), if applicable.

This form covers the events below. Please select the event that has given rise to this claim:

Death of the main member (please complete sections A, B, C, F, G, H, I, and K)

Disability of the main member (please complete sections A, B, C, D, E, I and K)

Death of another insured, i.e. spouse, parent or child (please complete section A, B, C, E, F, G, H and K)

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SECTION A: POLICY DETAILS

Employer:	<input type="text"/>
Policyholder:	<input type="text"/>
Policy number:	<input type="text"/>
Membership / Employee number:	<input type="text"/>

SECTION B: EMPLOYER'S DETAILS

Name of company:	<input type="text"/>
Physical address:	<input type="text"/>
	<input type="text" value="Code:"/>
*Company Authority name:	<input type="text"/>
Company Authority ID number:	<input type="text"/>
Job title / designation:	<input type="text"/>
Contact number:	<input type="text"/>
Email address:	<input type="text"/>

**The Company Authority is a representative from the employer / fund who is authorised to complete and sign this form, e.g. HR representative, company director, etc.*

SECTION C: MAIN MEMBER'S PERSONAL DETAILS

First names:	<input type="text"/>
Surname:	<input type="text"/>
Identity number:	<input type="text"/>
Date of birth:	<input type="text" value="Gender:"/>

SECTION D: DISABILITY DETAILS OF MAIN MEMBER (only complete if applicable)

Date of disability:	<input type="text"/>
Cause of disability:	<input type="text"/>
Name of insurance company:	<input type="text"/>

SECTION E: DECEASED'S PERSONAL DETAILS (only complete if the deceased is not the main member, but another insured)

First names:	<input type="text"/>
Surname:	<input type="text"/>
Identity number:	<input type="text"/>
Date of birth:	<input type="text" value="Gender:"/>

SECTION F: GENERAL DETAILS

Month for which last premium was paid:

Was the deceased at work on date of death? ☐ Yes ☐ No

If "No" please provide details below

Date when the deceased was last at work:

Reason for absence from work:

Salary for the month prior to date of death:

Has the deceased been absent from *Southern Africa? ☐ Yes ☐ No

**Southern African: Angola, Botswana, Eswatini, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Zambia*

If "Yes" please provide details, including period absent from Southern Africa:

SECTION G: CLAIM DETAILS

Date of death:

Cause of death:

Was the death as a result from an accident? ☐ Yes ☐ No

If death is a result of an accident please ensure a Police Report is attached to this claim application.

SECTION H: BANKING DETAILS

Payment will be made to the nominated beneficiary/ies as per the Nomination of Beneficiary form.

Name of primary beneficiary:

Identity number:

Benefit percentage: (%) Relationship to deceased:

Contact number:

Address:

Code:

Name of bank:

Branch:

Account type:

Account number:

Name of backup beneficiary:

Identity number:

Benefit percentage:

Contact number:

Address:

Name of bank:

Branch:

Account type:

Account number:

SECTION I: PAID-UP BENEFITS

Paid-up benefits are only available in the event of the main member's death or disability. Note that Hollard Group Risk must be notified of all insureds for whom paid-up benefits are required, within 3 months of the date of the main member's death or disability.

Spouse of main member (maximum of 1):

Identity number:

Date of birth:

Parent of main member:

Identity number:

Date of birth:

Parent of main member:

Identity number:

Date of birth:

Parent of spouse:

Identity number:

Date of birth:

Parent of spouse:

Identity number:

Date of birth:

Child name:	<input type="text"/>
Identity number:	<input type="text"/>
Date of birth:	<input type="text" value="Gender:"/>
Child name:	<input type="text"/>
Identity number:	<input type="text"/>
Date of birth:	<input type="text" value="Gender:"/>
Child name:	<input type="text"/>
Identity number:	<input type="text"/>
Date of birth:	<input type="text" value="Gender:"/>
Child name:	<input type="text"/>
Identity number:	<input type="text"/>
Date of birth:	<input type="text" value="Gender:"/>

If more space is required, please attach a sheet to this form.

A paid-up benefit certificate will be issued to the nominated caretaker (parent/guardian).

It should be noted that the benefits set out in the paid-up benefit certificate will only be in force whilst the Group Funeral Benefit Scheme remains insured by Hollard Group Risk.

SECTION J: PRIVACY STATEMENT

We respect the confidentiality of your personal information as well as your privacy. If necessary, we may need to share your personal information 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 parties as is applied by us. By providing the required personal information and signing this form, you consent to us processing and sharing your personal information with 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 for marketing additional products and/or services.

SECTION K: 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 Group Risk. If this claim or any supporting claim documentation is found to be fraudulent, Hollard Group Risk reserves the right to proceed with the appropriate action against the claimant.

I authorise Hollard Group Risk to make payment as instructed above and I acknowledge that payment of the benefits claimed, shall release Hollard Group Risk from all liability in respect of such benefits. I consent to any medical practitioner, hospital or other third party to provide Hollard Group Risk with any information they may require relating to the deceased (e.g. medical information, accident and police reports etc.), which may be necessary for assessment 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.

Company Authority signature

Date