

## PAID-UP FUNERAL BENEFIT CLAIM FORM

Hollard Group Risk extends our heartfelt condolences on the loss of the insured.

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 deceased's death certificate (copy of ID Book / front and back of Smart ID Card).
- a copy of the deceased's identity document (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.
- an original certified copy of proof of the relationship of the claimant to the deceased.
- 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 banking details (bank statement not older than 3 months or account confirmation letter from bank).

## SECTION A: POLICY DETAILS

Employer/ Policyholder:	<input type="text"/>
Policy number:	<input type="text"/>
Paid-up benefit certificate number:	<input type="text"/>
Paid-up benefit certificate effective date:	<input type="text"/>

## SECTION B: 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"/>
	Gender: <input type="text"/>

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### SECTION C: DECEASED'S PERSONAL DETAILS

First names:	<input type="text"/>
Surname:	<input type="text"/>
Identity number:	<input type="text"/>
Date of birth:	<input type="text"/> Gender: <input type="text"/>
Relationship to main member:	<input type="text"/>

### SECTION D: CLAIMANT'S PERSONAL DETAILS

First names:	<input type="text"/>
Surname:	<input type="text"/>
Identity number:	<input type="text"/>
Date of birth:	<input type="text"/> Gender: <input type="text"/>
Relationship to main member:	<input type="text"/>

### SECTION E: CLAIM DETAILS

Date of death:	<input type="text"/>	dd/mm/yyyy
Cause of death:	<input type="text"/>	
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 F: BANKING DETAILS

Payment will be made to the claimant only.

Account holder name:	<input type="text"/>
Name of bank:	<input type="text"/>
Branch:	<input type="text"/>
Branch code:	<input type="text"/>
Account type:	<input type="text"/>
Account number:	<input type="text"/>

## SECTION G: 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 H: DECLARATION AND CONSENT

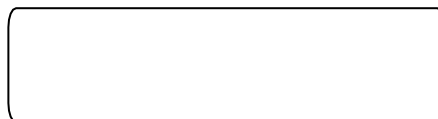
I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Group Risk. If this claim or any supporting claim documentation is found to be fraudulent, Hollard Group Risk reserves the right to proceed with the appropriate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



Company Authority signature



Date

**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](mailto:Hollard@tip-offs.com).**