SPOUSE'S DEATH 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.

- ☐ Copy of the employee's identity document (copy of ID Book / front and back of Smart ID Card).
- ☐ Copy of proof of the relationship between the deceased and the main member i.e. marriage certificate, or affidavit.
- ☐ Copy of the insured's death certificate.
- ☐ Copy of the insured's identity document (copy of ID Book / front and back of Smart ID Card).
- ☐ Copy of the employee's last payslip.Copy of the completed DHA 1663 (notice of death / stillbirth) report.
- ☐ Copy of the Police Report for Unnatural Cause of Death from the South African Police Service (if applicable).
- ☐ Copies of the beneficiaries' identity documents (copy of ID Book / front and back of Smart ID Card), or birth certificates (for minors). This should be for the beneficiaries indicated in the latest beneficiary nomination form.
- ☐ Proof of the beneficiaries' banking details not older than 3 months (bank statement / account confirmation letter from bank), or trust details for minors.

Hollard Group Risk reserves the right to request additional information if necessary.

SECTION A: POLICY DETAILS

Employer/ Policyholder: _____

Policy number: _____

Membership / Employee number: _____

SECTION B: EMPLOYER’S DETAILS

Name of company:

Physical address:

Code:

*Company Authority name:

Company Authority ID number:

Job title / designation:

Contact number:

Email address:

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SECTION C: MAIN MEMBER'S PERSONAL DETAILS

First names:

Surname:

Identity number:

Date of birth: dd/mm/yyyy

Employment start date: dd/mm/yyyy

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First names:

Surname:

Identity number:

Date of birth: dd/mm/yyyy

Relationship to main member: Gender:

SECTION D: GENERAL DETAILS

Month for which last premium was paid: mm/yyyy

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: dd/mm/yyyy

Reason for absence from work:

Salary for the month prior to date of death: R

*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 E: CLAIM DETAILS

Date of death: dd/mm/yyyy

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 F: BANKING DETAILS

We will pay the insured's death benefit as a lump sum to the main member. If the main member is no longer alive at the time of benefit payment, we will pay the insured's death benefit as a lump sum to the insured's estate.

Main member:

Identity number:

Benefit percentage: % Relationship to deceased:

Contact number:

Physical address:

Code:

Name of bank:

Branch: Code:

Account type:

Account number:

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.

I confirm that the nomination of beneficiary form provided to Hollard Group Risk is the last / most recently completed one in the member's personal file.

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.