Hollard.

DEATH CLAIM FORM

(To be completed by claimant)

Please note that it is essential to complete this form in full to prevent unnecessary delays as a result of missing information.

Where there is more than one beneficiary or policyholder, each claimant needs to complete and submit this form.

The following must be included when submitting this form:

a. A certified copy of the death certificate
b. A certified copy of the deceased's identity document
c. A certified copy of the claimant's identity document
d. For unnatural death, we require the Hollard Life Death Claim form to be fully completed by the police investigating officer
e. A certified copy of the letter of executorship in the event of no beneficiary nomination
f. Proof of bank account details of the claimant (e.g. copy of original bank statement within 3 months)
g. Proof of residence if address is not on the bank statement
h. Death Claim Form by medical attendant, to be completed by the deceased's usual medical attendant

Return the completed form and the above documents to lifeclaims@hollard.co.za or fax to 086 659 0135.

1. Life Insured details

Full name _____

Identity no. | Y | Y | M | M | D | D | | | | | | | |

Relationship between claimant and deceased (e.g. father/son) _____

Name of employer prior to death _____

Occupation prior to death _____

2. Claimant details

Policy no. _____ Identity no. _____

Name of claimant _____

Date of birth | D | D | M | M | Y | Y | Y | Y | Work tel. no. _____

Home tel. no. _____ Cell no. _____

Email address _____ Mandatory

Physical address _____ Postal code _____

Postal address _____ Postal code _____

Country of residence _____

Employer's name _____

Occupation _____

3. Details of the death

Date of death | D | D | M | M | Y | Y | Y | Y |

Hospital/place of death:

Name _____

Address _____ Postal code _____

Contact no. _____

Provide full details of the cause of death ('natural causes' or 'unnatural death' is not acceptable – state the circumstances leading to death)

Cemetery place of burial

Funeral parlour that directed the burial:
Name
Address
Postal code
Contact no.

Name of police station where death was reported

Police case number (where applicable, e.g. unnatural causes)

Name of the investigating officer and contact number

Medical attendant who certified the death:
Name
Address
Postal code
Contact no.

4. Details of doctor (usual medical attendant)

Name and surname

Tel. no.

Name, address and telephone number of each doctor that attended to or prescribed anything for the deceased during the five years preceding death

5. Declaration by claimant

I am entitled to make a claim on this policy and accept that the proceeds arising from this claim will be payable to:

a. the cessionary on Hollard Life records if the policy has been ceded, otherwise to
b. the nominated beneficiaries if the policyholder is deceased, or to
c. the estate of the deceased policyholder if no beneficiaries have been nominated, or to
d. the policyholder in all other circumstances.

I declare that the statements above are true and complete. In the event that this claim or any supporting documentation is found to be fraudulent, Hollard Life reserves the right to proceed with the appropriate action against me.

I further authorise any medical attendant or any other person who has attended to the life insured, or any hospital or other institution that has medical information about the life insured, to disclose this information to Hollard Life.

Please take note of the following Hollard disclosures:

Protection of Personal Information Act (POPIA)

Hollard cares about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this form. We will treat this information with caution and we have put reasonable security measures in place to protect it.

Financial Intelligence Centre Amendment Act (FICAA)

In accordance with applicable anti-money laundering laws in South Africa, we are required to obtain specific information and evidence to verify your identify (and in many cases the identities of related persons, such as but not limited to directors, beneficial owners and persons instructing us on your behalf (where applicable)) when applying for cover and on an on-going basis. If we ask you for information or documents (including originals or certified copies) you must provide them to us as soon as possible. If we do not receive adequate information and evidence within a reasonable time of our request we may be unable to provide you with cover or may cancel the policy in accordance with applicable law.

Full name _____

Signature _____ **Date** | D | D | M | M | Y | Y | Y | Y |