Hollard.

DEATH CLAIM FORM

(To be completed by medical attendant)

Your claim will only be considered if every question has been completed in full.

Please note that Hollard Life will not pay for the completion of this form.

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

1. Policy details

Policy no. ____________________ Identity no. ____________________

Name of insured ____________________

Occupation ____________________

Date of birth D D M M Y Y Y Y Date of death D D M M Y Y Y Y

Place of death ____________________

Duration of illness if natural causes ____________________

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

____

____

____

1. Was the death as a result of illness? YES ☐ NO ☐

   If YES:

   a. Date when the deceased first became aware of it or any symptoms D D M M Y Y Y Y

   b. Date when the illness was diagnosed D D M M Y Y Y Y

   State any disease or conditions which preceded or co-existed with the immediate cause of death and the date of diagnosis

   Condition ☐ D D M M Y Y Y Y

   Condition ☐ D D M M Y Y Y Y

   Condition ☐ D D M M Y Y Y Y

   Condition ☐ D D M M Y Y Y Y

   Indicate any other complaints for which the deceased consulted you and date of diagnosis

   Condition ☐ D D M M Y Y Y Y

   Condition ☐ D D M M Y Y Y Y

   Condition ☐ D D M M Y Y Y Y

   Condition ☐ D D M M Y Y Y Y

2. Was the death as a result of an accident? YES ☐ NO ☐

   If YES:

   a. When did you first attend to the deceased with regard to the injuries sustained in the accident? D D M M Y Y Y Y

   b. Are you the usual medical attendant of the deceased? YES ☐ NO ☐

   If YES, how long have you known him/her? ____________________

Hollard.

If NO, supply the name, address and telephone number of the usual medical attendant

____

____

____

c. Give full details of the nature of the injuries sustained by the deceased

____

____

____

3. a. Is there any reason to believe that the deceased's death is in any way due to AIDS or HIV infection? YES ☐ NO ☐

If YES, give full details

____

____

b. Has the deceased ever been tested for HIV antibodies? YES ☐ NO ☐

If YES, what was the result of the test and when was it done?

______________________________ | D | D | M | M | Y | Y | Y | Y |

4. Indicate the names and addresses of any other doctor(s) consulted by the deceased during the past 5 years, other than these mentioned above

____

____

____

5. Did the deceased use tobacco in any form? YES ☐ NO ☐

6. Was an inquest or post mortem inquiry held? YES ☐ NO ☐

7. Provide any other relevant facts relating to the deceased's family history or habits pertaining to this claim

____

____

____

Declaration by medical attendant

I declare that I have personally attended to the patient and that this form has been completed to the best of my knowledge.

Full name ____

Qualifications ____

Practice no. ______________ Work tel. no. ______________ Cell no. ______________

Email address ____

Postal address ____

Signature ______________________________ **Date** | D | D | M | M | Y | Y | Y | Y |

Hollard Declaration

We respect and adhere to patient confidentiality and data privacy principles in relation to Personal Information. We will therefore only process this information for the purpose for which it is intended.