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DEATH CLAIM FORM

FOR DEATH/FINAL EXPENSES/FUNERAL CLAIMS

Policy number:

To be filled in by the contact person

- To process claims efficiently, we may need to contact someone who can provide or confirm information that will assist in the claim validation process. If you are the contact person for this claim, please fill in this form.
- You do not need to be a beneficiary of this death claim to complete this form – but you must be the contact person. Beneficiaries must complete the separate BENEFICIARY FORM. If you are both the contact person as well as the beneficiary, you must fill in this form as well as the BENEFICIARY FORM.
- To find out exactly what documents you need to provide us with for your claim, please ask for our HOW TO SUBMIT A DEATH CLAIM information page.
- The contact person is responsible for providing information that is true and accurate, to the best of your knowledge. At the end of this form, you need to sign to indicate that you have given us true and correct information. You also need to sign your permission for us to confirm your information with any other source.

1. CONTACT PERSON'S DETAILS

Title Mr: Ms: Mrs: Other: Initials:

First names: Surname:

ID number:

Relationship to the deceased: Family member: Executor of estate:

Other: (please explain)

Contact numbers

Work: Home:

Fax: Cellphone:

Email address:

Residential address if different to postal address:

Postal address:

Are you also a beneficiary of this policy? Y N If "YES", please fill in the separate BENEFICIARY FORM.

2. DETAILS OF DECEASED

To confirm information about the deceased, we need to know the following information about the deceased:

Title Mr: Ms: Mrs: Other: Initials:

First names: Surname:

ID number: Income tax number:

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

Cause of death: Natural: (i.e. old age or illness) Unnatural: (i.e. car accident or victim of crime)

Please provide more information about the cause of death:

Was the deceased insured with any other company? Y N If "YES", please supply full details:

Company name: Policy number:

Company name: Policy number:

Is there a cession or interest affecting the owner's rights under this policy? Y N

If "YES", please supply full details":

Has the deceased ever been insolvent or are there any sequestration proceedings pending or contemplated? Y N

If "YES", please supply full details":

3. MEDICAL INFORMATION

a) **Please fill this section in. We may need to contact the person who certified the death.**
Please provide the name of the hospital or medical practitioner who certified the death.

Name of hospital: Contact person:

Telephone: Cellphone number:

Email address:

Address:

b) **Medical history of deceased**
Please provide the names and addresses of the deceased's house doctor and any other doctor, hospital or clinic where the deceased received medical attention.

Name:

Address:

Approximate date of medical attention: Y Y Y Y M M D D

Reason for medical attention:

Name:

Address:

Approximate date of medical attention: Y Y Y Y M M D D

Reason for medical attention:

Name:

Address:

Approximate date of medical attention: Y Y Y Y M M D D

Reason for medical attention:

c) **Medical Aid details of deceased**

Did the deceased belong to a medical aid? Y N If "YES", please supply full details:

Name of Medical Aid:

Contact numbers:

Member number: Email address:

4. FUNERAL PARLOUR INFORMATION

We may need to contact the undertaker. Please fill this section in.

Name of funeral parlour: Contact person:

Telephone number: Cellphone number:

Email address:

Address:

5. EMPLOYER INFORMATION

We may need to contact the employer. Please fill this section in.

Name of employer: Contact person:

Telephone number: Cellphone number:

Email address:

Address:

6. DECLARATION OF CONTACT PERSON

I confirm that all the information provided on this form is true and accurate to the best of my knowledge.
I give Old Mutual consent to confirm the information provided with any other source.

Signed at: | the | day of | 20

Signature of Contact Person: