

CLAIM APPLICATION & DISCHARGE HOLLARD FUNERAL PLAN



TO BE COMPLETED BY THE CLAIMANT

Please read carefully the following paragraphs

GENERAL INFORMATION

1. Please use black ink and write clearly
2. To avoid administration delays, please ensure this application is completed in full and all supporting documents, as indicated in the *"list of documents to be attached to the claim"* are completed in full and attached to the claim
3. One application form must be used for one claim only
4. Every question must be completed in full
5. Fax the completed and signed documents to: 011 – (011) 351-3003 or email them to lifecclaimsadmin@hollard.co.za or post originals to - Life Claims - P O Box 87428 - HOUGHTON 2041

LIST OF DOCUMENTS TO BE ATTACHED TO THE CLAIM
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6. Original/Cerified copy of the printed death certificate must be supplied (no photocopies or Abridged Death Certificate's will be accepted)
7. Certified copy of BI-1663 Certificate, certified by a Hollard Life branch official or Commissioner of Oaths, must be supplied
8. Certified copy of ID book of deceased and claimant, certified by a Hollard Life branch official or Commissioner of Oaths, must be supplied
9. Police Report to be completed by the Investigating Officer in respect of unnatural deaths in the first 6 months
10. Road traffic accident Report if the claim is in the first 6 months and the death is as a result of a motor vehicle accident
11. Certified copy of the drivers license where applicable if the death is as a result of a motor vehicle accident
12. Proof of full time education if deceased is over the age of 21 years and under the age of 25 year
13. Letter of executorships where applicable
14. Proof of marriage where applicable

SECTION 1. CONTRACT DETAILS	
DETAILS OF SCHEME	
Scheme name	
Contract/Policy Number	
DETAILS OF POLICYHOLDER	
Surname	
Full Names	
ID number	

Contract/Policy Number																			
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SECTION 2 - DETAILS OF DECEASED										
Surname										
Full Names										
Sex		Male			<input type="checkbox"/>	Female			<input type="checkbox"/>	
Date of Birth										
I.D. Number (please submit proof)										
Residential address										
Postal address								Postal code		
Tel no Home				Cell phone				Tel no work		
E-mail address										
Relationship between deceased and claimant (e.g. the deceased is the father / son etc.)										
Relationship between deceased and policyholder (e.g. the deceased is the father / son etc.) if claimant and policyholder are not the same person										

SECTION 3 - DETAILS OF EMPLOYMENT PRIOR TO DEATH									
Name of Employer									
Nature of business									
Postal Address								Postal code	
Telephone number					Fax number				
E-mail address									
Job title/Occupation at time of death									

Contract/Policy Number																				
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SECTION 4 DETAILS OF THE DEATH OF THE LIFE ASSURED

a) Date of death		
b) Time of death		
c) Hospital/Place of death		
d) Hospital Address		
e) Hospital telephone number		
f) Hospital admission number/patient number		
g) Cause of death (PLEASE GIVE FULL DETAILS – “Natural Causes” not acceptable); if “Unnatural Death”, please explain the circumstances that lead to the death:		
h) Date of funeral		
i) Place/cemetery where buried		
j) Details of funeral parlour that directed the burial:		
1) Name of funeral parlour		
2) Address		
3) Telephone number		
4) Contact Person		
5) Funeral Parlour Designation Number		
k) Details of doctor who certified death		
1) Name		
2) Address		
3) Telephone number		
4) Doctor Practice number		
l) Where applicable, e.g. Unnatural Cause		
1) Police station where death was reported		
2) Police case number		

Contract/Policy Number																				
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3) Investigating Officer name		
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4) Investigating Officer telephone number		
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SECTION 5 - DETAILS OF CLAIMANT

Surname		
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Full Names		
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I.D. Number (please submit proof)		
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Residential address		

Postal address		
		Postal code

Tel no Home		Cell phone		Tel no work	
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E-mail address		
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Claimant occupation		
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Employer Name		
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Employer Work Address		

SECTION 6 – OTHER INFORMATION:

Name of headman/tribal chief		
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Address of headman/tribal chief		
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Telephone number of headman/tribal chief		
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Please complete if the deceased was a child		
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Name of school		
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Address of school		

Telephone number of school		
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Name of school principal		
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Address of school principal		

Telephone number of school principal		
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Contract/Policy Number																			
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SECTION 7. ELECTRONIC TRANSFER AUTHORIZATION

I hereby request and authorize Hollard Life Assurance Corporation (LTD) to electronically transfer payments into my Account

Account holder

Account holder ID No.

Account holder Contact Tel. No.

Policy/contract Number

Name of Bank

Branch NumberBranch/Town.....

Account Number

Type of Account Current Saving Transmission

Authorized Signatures

Account Holder _____

Claimant _____

Contract/Policy Number																			
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SECTION 8. DECLARATION BY CLAIMANT ****

I,the claimant hereby notify HOLLARD LIFE ASSURANCE COMPANY of the death of the life assured and declare that the foregoing answers and full statements are true and correct. 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 the claimant or other parties involved.

It is essential for insurance companies to share claims and underwriting information (as well as credit information) in order to enable the fair assessment and underwriting of risks and to reduce the number of fraudulent claims.

1. On my behalf and on behalf of any person I represent herein, I hereby waive any right to privacy in any insurance information provided by me or on my behalf for any insurance policy or claim made or lodged by me or on my behalf and I agree to such information being disclosed to any other insurance company.
2. The information provided by me or the Insured may be verified against other sources or databases.
3. I also waive any rights of privacy and consent to the disclosure of any information relevant to any insurance policy or insurance claim concerning myself or the insured.

I hereby make claim to the benefits of the insurance with HOLLARD LIFE ASSURANCE COMPANY and agree that the written statements and affidavits of all the doctors who attended or treated the deceased and all other documentation furnished in support of this claim shall constitute and are hereby made a part of this claim and further agree that the furnishing of this form, or any other forms supplemental hereto, by the company shall not constitute or be considered an admission by HOLLARD LIFE ASSURANCE COMPANY that there was any insurance in force on the life in question or a waiver of any of its rights or defences in law.

I hereby irrevocably authorise any medical practitioner, hospital or any other person to disclose or handover to HOLLARD LIFE ASSURANCE COMPANY, or its representative, any details and documents relating to illness, injury or general information relevant to the claim or such information as may be necessary to consider this claim.

Date (DD/MM/CCYY)..... Signature of claimant.....
 Address of claimant

 Telephone number (W) (.....)
 Telephone number (H) (.....)
 Cell No

Date (DDMMYY) Signature of witness.....
 Full names and surname of witness:
 Contact number of witness:
 ID number of witness:
 Address of witness.....

