



CLAIM APPLICATION & DISCHARGE

DECLARATION OF NOMINATED BENEFICIARY/CLAIMANT WHO IS SUBMITTING THIS CLAIM

I \_\_\_\_\_ (full names printed), declare that the facts and details in this application are accurate and true and correct. I agree and understand that should any of the facts, documentation or information provided, not be true or correct in any way whatsoever, The Company reserves the right to cancel this policy and to proceed with the appropriate action against the claimant.

Signature of beneficiary \_\_\_\_\_ Date \_\_\_\_\_

Full names and surname of beneficiary \_\_\_\_\_

Signature of witness \_\_\_\_\_ Date \_\_\_\_\_

Full names and surname of witness \_\_\_\_\_

Contact Tel of beneficiary \_\_\_\_\_ Contact Tel of witness \_\_\_\_\_

PAYMENT DETAILS

I, the beneficiary, request the cheque be made payable to \_\_\_\_\_

I, the beneficiary, request that payment be made into the following bank account

Name of account holder \_\_\_\_\_

Bank name \_\_\_\_\_

Bank Account number \_\_\_\_\_ Branch \_\_\_\_\_

Account holder's Signature \_\_\_\_\_ Date \_\_\_\_\_

Beneficiary's Signature \_\_\_\_\_ Date \_\_\_\_\_

The binder holder, LifeWise has entered into an agreement with the insurers which authorises it to enter into, vary or renew an insurance policy and settle claims. For performing the above mentioned functions, the binder holder is paid a maximum fee of 20% of gross written premium.

OFFICE USE ONLY

- A. Policy document checked, endorsed, and returned to beneficiary. Yes No
B. Original death certificate received. Yes No
C. Correctly certified copy of claimant's identity document. Yes No
D. Correctly certified copy of deceased' identity document. Yes No
I, \_\_\_\_\_ (full names printed), of \_\_\_\_\_ Branch, certify that items A, B, C, and D were checked by myself. I also certify that the death verification was processed by myself.
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Binder Disclosure: The binder holder, LifeWise, has entered into an agreement with Hollard Life Assurance Company Limited, an Authorised Financial Services Provider, which authorises it to enter into, vary or renew an insurance policy, collect premiums and settle claims. For performing the abovementioned functions, the binder holder is paid a maximum fee of 20% of gross written premium.



CLAIM APPLICATION & DISCHARGE

Family Expenses Southern Africa (Pty) Limited

Somerset Office Estate, 604 Kudu Street, Allen's Nek, Roodepoort 1737. PO Box 3294, Florida 1710. Tel 011 472 2020. Email: claims@staylifewise.co.za

EVERY QUESTION MUST BE COMPLETED IN FULL. (Please complete in black ink)

PLEASE NOTE THAT A CLAIM WILL ONLY BE CONSIDERED UNDER THE FOLLOWING CONDITIONS:

- Original/Certified copy of the PRINTED death certificate must be supplied (no photocopies or Abridged Death Certificate's will be accepted).
Certified copy of ID book of deceased and claimant, certified by a LegalWise branch manager or Commissioner of Oaths must be supplied.
The claim will only be processed on receipt of all the original documentation and no faxes will be acceptable.
The nominated beneficiary must claim.
A copy of the bank statement must be submitted for electronic payments.
The BI 1663 form (details of death) from Home Affairs must be submitted.

Please return to: LifeWise Claims Division, PO Box 3294, Florida 1710. Tel 011 472 2020. Email: claims@staylifewise.co.za

Policy number \_\_\_\_\_

Full name of policy holder \_\_\_\_\_

DECEASED'S DETAILS

Full names and surname \_\_\_\_\_

ID number \_\_\_\_\_

Residential address \_\_\_\_\_

Postal address \_\_\_\_\_

code \_\_\_\_\_

Occupation prior to death \_\_\_\_\_

Work address \_\_\_\_\_

code \_\_\_\_\_

Name of employer prior to death \_\_\_\_\_

Telephone number of employer prior to death \_\_\_\_\_

Name & telephone number of next of kin (not claimant) \_\_\_\_\_



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### DETAILS OF DEATH

Date of death \_\_\_\_\_

Address of hospital/place of death \_\_\_\_\_  
\_\_\_\_\_

Telephone number of hospital/place of death \_\_\_\_\_

Hospital admission number/ patient number \_\_\_\_\_

Cause of death (Natural or Unnatural).  
If "Unnatural Death" please explain the circumstances that lead to the death \_\_\_\_\_  
\_\_\_\_\_

Date of funeral \_\_\_\_\_

Place/cemetery to be buried \_\_\_\_\_

Name and details of person responsible for payment of funeral \_\_\_\_\_  
\_\_\_\_\_

Name of funeral parlour \_\_\_\_\_

Address of funeral parlour that directed the burial \_\_\_\_\_  
\_\_\_\_\_

Telephone number of funeral parlour that directed the burial \_\_\_\_\_

Police station where death was reported \_\_\_\_\_

Police case number (where applicable, e.g. Unnatural Cause) \_\_\_\_\_

Investigating Officer and telephone number \_\_\_\_\_

Name, address and telephone number of doctor who certified death: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### DETAILS OF NOMINATED BENEFICIARY/CLAIMANT WHO IS SUBMITTING THIS CLAIM

Full names and surname \_\_\_\_\_

ID number \_\_\_\_\_

Residential address \_\_\_\_\_  
\_\_\_\_\_ code \_\_\_\_\_

Postal address \_\_\_\_\_  
\_\_\_\_\_ code \_\_\_\_\_

Work telephone number \_\_\_\_\_

Home telephone number \_\_\_\_\_

Cellular telephone number \_\_\_\_\_

Employer name and work address \_\_\_\_\_  
\_\_\_\_\_ code \_\_\_\_\_

Telephone number of employer \_\_\_\_\_

Relationship between claimant and deceased (e.g. father/son etc) \_\_\_\_\_

### OTHER INFORMATION

Name of headman/ tribal chief \_\_\_\_\_

Address and telephone number of headman/ tribal chief \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If deceased was a child - name, address, telephone number and name of school and principal \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_