

### How to claim

It is essential that this form is fully completed to prevent unnecessary delays due to missing or incomplete information. This form should be completed by the policyholder and sent to [claimslife@hollandnam.com](mailto:claimslife@hollandnam.com). Copies must be certified copies of the original documents.

**This fully completed form should be accompanied by the following supporting documentation:**

- ☐ An original certified copy of the main member's identity document or passport.
- ☐ An original certified copy of the deceased's death certificate & Medical Certificate, and burial order.
- ☐ A copy of the main member's last pays lip. A copy of the beneficiary listed form.
- ☐ Proof of banking details and completed FIA form.
- ☐ Original certified copy of the beneficiary's identity document or passport if payment is being made to a beneficiary and not the policyholder, plus bank letter & Fia Form.
- ☐ A copy of the accident/ police report if cause of death was accidental, and the CR Number must be provided.
- ☐ If applicable, proof of the deceased's relationship to the main member (e.g., marriage certificate, full birth certificate or affidavit)

### Scheme Details

|                |                      |
|----------------|----------------------|
| Employer:      | <input type="text"/> |
| Policyholder:  | <input type="text"/> |
| Policy number: | <input type="text"/> |

### Employer's Details

|                   |                      |                 |                      |
|-------------------|----------------------|-----------------|----------------------|
| Name of Company:  | <input type="text"/> |                 |                      |
| Physical Address: | <input type="text"/> | Postal Address: | <input type="text"/> |
|                   | <input type="text"/> |                 | <input type="text"/> |
| Contact Person:   | <input type="text"/> | Job Title:      | <input type="text"/> |
| Telephone Number: | <input type="text"/> | Email Address:  | <input type="text"/> |

### Main Member's Personal Details

|                           |                                |                                |                                |                                |                                |                                |                                |                                |         |                            |                              |
|---------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|---------|----------------------------|------------------------------|
| First Names:              | <input type="text"/>           |                                |                                |                                |                                |                                |                                |                                |         |                            |                              |
| Surname:                  | <input type="text"/>           |                                |                                |                                |                                |                                |                                |                                |         |                            |                              |
| Identity/Passport Number: | <input type="text"/>           |                                |                                |                                |                                |                                |                                |                                |         |                            |                              |
| Date of Birth:            | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="M"/> | <input type="text" value="M"/> | <input type="text" value="D"/> | <input type="text" value="D"/> | Gender: | <input type="radio"/> Male | <input type="radio"/> Female |

## Deceased's Personal Details

|                              |                                |                                |                                |                                |                                |                                |                                |                                |         |                                                         |
|------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|---------|---------------------------------------------------------|
| First Names:                 | <input type="text"/>           |                                |                                |                                |                                |                                |                                |                                |         |                                                         |
| Surname:                     | <input type="text"/>           |                                |                                |                                |                                |                                |                                |                                |         |                                                         |
| Date of Death:               | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="M"/> | <input type="text" value="M"/> | <input type="text" value="D"/> | <input type="text" value="D"/> |         |                                                         |
| Identity/Passport Number:    | <input type="text"/>           |                                |                                |                                |                                |                                |                                |                                |         |                                                         |
| Date of Birth:               | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="M"/> | <input type="text" value="M"/> | <input type="text" value="D"/> | <input type="text" value="D"/> | Gender: | <input type="radio"/> Male <input type="radio"/> Female |
| Relationship to main member: | <input type="text"/>           |                                |                                |                                |                                |                                |                                |                                |         |                                                         |

## General Details

|                                                                                            |                                                    |  |  |  |  |  |  |  |  |  |
|--------------------------------------------------------------------------------------------|----------------------------------------------------|--|--|--|--|--|--|--|--|--|
| Month for which the last risk contribution was paid:                                       | <input type="text"/>                               |  |  |  |  |  |  |  |  |  |
| Was the deceased at work on the date of death?                                             | <input type="radio"/> Yes <input type="radio"/> No |  |  |  |  |  |  |  |  |  |
| If no, please give the date when the deceased was last at work and the reason for absence: |                                                    |  |  |  |  |  |  |  |  |  |
| <input type="text"/>                                                                       |                                                    |  |  |  |  |  |  |  |  |  |
| Has the deceased been employed in any territory outside the SADC region?                   | <input type="radio"/> Yes <input type="radio"/> No |  |  |  |  |  |  |  |  |  |
| If yes, please provide details:                                                            |                                                    |  |  |  |  |  |  |  |  |  |
| <input type="text"/>                                                                       |                                                    |  |  |  |  |  |  |  |  |  |

## Claim details

|                 |                                |                                |                                |                                |                                |                                |                                |                                |
|-----------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| Date of Death:  | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="Y"/> | <input type="text" value="M"/> | <input type="text" value="M"/> | <input type="text" value="D"/> | <input type="text" value="D"/> |
| Cause of Death: | <input type="text"/>           |                                |                                |                                |                                |                                |                                |                                |

If death was as a result of an accident, please ensure that the accident report is included.

## Banking Details

|                                                                  |                      |                                    |                            |                              |
|------------------------------------------------------------------|----------------------|------------------------------------|----------------------------|------------------------------|
| Please indicate to whom payment should be made                   |                      | <input type="radio"/> Policyholder | <input type="radio"/> Fund | <input type="radio"/> Other* |
| *if other, please provide proof of relationship to the deceased. |                      | <input type="text"/>               |                            |                              |
| Name of Account Holder:                                          | <input type="text"/> |                                    |                            |                              |
| Name of Bank:                                                    | <input type="text"/> |                                    |                            |                              |
| Branch                                                           | <input type="text"/> | Branch Code:                       | <input type="text"/>       |                              |
| Account Number:                                                  | <input type="text"/> | Account Type:                      | <input type="text"/>       |                              |

## Declaration

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from the insurer. In the event that this claim or any supporting claim documentation is found to be fraudulent, the insurer reserves the right to proceed with the appropriate action against the claimant.

I authorise the insurer to make payment as instructed above and I acknowledge that payment by the insurer of the benefits claimed, shall release the insurer from all liability in respect of such benefits.

I authorise any medical practitioner, hospital or other person to provide the insurer with any information that they may require relating to the deceased's medical history and / or injury which may be necessary for the insurer's consideration of the claim.

Signed at (place)  on this  day of  2 0

Name of Authorised Signatory

Designation

Signature

Company Stamp