inploy
insurance for your employees

# FUNERAL BENEFIT
## CLAIM FORM

## 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. If we ask for an original certified copy of a document we will not accept a certified copy of a previously certified copy.

**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
- ◯ a copy of the main member's last payslip
- ◯ proof of banking details
- ◯ original certified copy of the beneficiaries identity document or passport if payment is being made to a beneficiary and not the policyholder.
- ◯ a copy of the accident report form (if cause of death was accident)
- ◯ if applicable, proof of the deceased's relationship to the main member (e.g. marriage certificate, full birth certificate or affidavit)

## Scheme Details

Employer:

Policyholder:

Policy number:

## Employer's Details

Name of Company:

Physical Address:

Postal Address:

Contact Person:

Job Title:

Telephone Number:

Email Address:

## Main Member's Personal Details

First Names:

Surname:

Identity/Passport Number:

Date of Birth: Y Y Y Y M M D D

Gender: ◯ Male ◯ Female

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## Deceased's Personal Details

First Names:

Surname:

Identity/Passport Number:

Date of Birth: Y Y Y Y M M D D Gender: ◯ Male ◯ Female

Relationship to main member:

## General Details

Month for which the last risk contribution was paid:

Was the deceased at work on the date of death? ◯ Yes ◯ No

If no, please give the date when the deceased was last at work and the reason for absence:

Has the deceased been employed in any territory outside the SADC region? ◯ Yes ◯ No

If yes, please provide details:

## Claim details

Date of Birth: Y Y Y Y M M D D

Cause of Death:

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 ◯ Policyholder ◯ Fund ◯ Other*

*if other, please provide proof of relationship to the deceased.

Name of Account Holder:

Name of Bank:

Branch Branch Code:

Account Number: Account Type:

## 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 Y Y

Name of Authorised Signatory _____

Designation _____

_____
Signature

_____
Company Stamp