APPLICATION FOR PAYMENT OF DEATH CLAIM

CLAIM REQUIREMENTS

1. Application for Payment of a Death Claim form completed by beneficiary or executor
2. Certificate of Medical Attendant completed by regular family doctor prior to (commencement or reinstatement date)
3. Death Claims Medical Questionnaire completed by the doctor or emergency personnel who certified the death
4. Copies of medical aid claim statements (if applicable)
5. Certified copy of death certificate
6. BI1663 form or DHA1663 Form – Notification/ Register of Death
7. Burial Order form
8. Certified copy of life assured's ID document, no more than three (3) months old
9. Certified copy of beneficiary's ID document of, no more than three (3) months old
10. Certified copy of marriage certificate if the insured's spouse is a beneficiary not > 3 months old
11. Three (3) months bank statement of the life assured prior to death
12. Three (3) months bank statement of the claimant
13. Letter of Executorships (if applicable).

If the deceased died due to unnatural causes, the following would be required as well:

1. Police report – to be completed by the investigating officer
2. Full post mortem report
3. Body Identification form
4. Road traffic accident report (if applicable).

If the proceeds of the policy are payable to a minor child, payment will only be made into the guardian's fund or a registered trust account whereby the minor child is the nominated beneficiary.

ENQUIRIES

For all claims related enquiries, please contact the claims department.

- Telephone: 0860 10 51 96
- Fax: 086 010 5767
- E-mail: claims@1life.co.za.

IMPORTANT CLAIM TIME LIMITS

1Life must be notified of an event that may result in a claim for a death benefit within 6 (six) months of its occurrence. We may reject a claim if we do not receive notification within the prescribed periods.

- Initial claims documentation must reach us within 3 (three) months of the claim event
- Any additional documents required for processing the claim need must reach us within 3 (three) months of us requesting them
- 1Life reserves the right to request further information that they deem necessary to complete the assessment of the claim
- Incomplete and/ or insufficient information may result in delays of the claim assessment. .

COMPLETED FORMS

The required documents plus this claim form, correctly completed and signed, must be submitted to 1Life using by fax (086 010 5767) or email (claims@1life.co.za).

If there is more than one beneficiary, each beneficiary must complete a separate claim form.

1Life may require additional information in order to reach a decision on the claim.

SECTION A: PARTICULARS OF THE INSURED (DECEASED)

1. Policy Number _____ Title _____ Initials _____ Gender _____

First Names _____ Surname _____

ID/ Passport _____ Language _____

Postal Address _____

_____ Code _____

Physical Address _____

_____ Code _____

Telephone (Work) _____ Fax (Work)

Telephone (Home) _____ Fax (Home) _____

Cell _____ E-mail _____

2. Date of Death _____ 3. Date of Burial/ Cremation _____

4. Place of Burial _____

5. Grave Number _____ 6. Funeral Undertaker _____

7. Detailed description of cause of death. _____

_____

_____

_____

_____

_____

_____

_____

8. List any illnesses or incidents for which the deceased was hospitalised in the past:

Date	Treating Doctor	Hospital	Diagnosis

SECTION A: PARTICULARS OF THE INSURED (DECEASED) CONTINUED

9. Details of all doctors who attended to the deceased during the five years preceding death.

a) Dr _____ Address _____

_____ Code

Telephone (Work) _____ Date Attended ____/____/____

b) Dr _____ Address _____

_____ Code _____

Telephone (Work) _____ Date Attended ____/____/____

c) Dr _____ Address _____

_____ Code _____

Telephone (Work) _____ Date Attended ____/____/____

10 Did the deceased commit suicide?

a) ☐ Yes ☐ No ☐ Under Investigation

Was the deceased's death caused by his/ her transgression of any law?

☐ Yes ☐ No ☐ Under Investigation

b) Was the deceased's death caused by another person's violence?

☐ Yes ☐ No ☐ Under Investigation

11. Was the deceased on medical aid? ☐ Yes ☐ No

12. Name of Medical Aid _____ 13. Medical Aid Number _____

13 Date Joined _____

14. Name of Hospital _____ 15. Hospital Ref Number _____

16. Company Where Deceased was Employed _____

Deceased's Occupation _____

Manager or Supervisor's Name and Surname _____

Physical Address _____

_____ Code _____

Telephone (work) _____ Employee Clocking Number _____

Hours Worked Per Week _____ Start Date of Employment ____/____/____

SECTION B: PARTICULARS OF CLAIMANT

Title _____ Initials _____ Gender _____

First Names _____ Surname _____

Relationship to Deceased _____

In what capacity is this claim lodged (beneficiary/ cessionary/ executor)? _____

ID/ Passport _____ Language _____

Postal Address _____

_____ Code _____

Physical Address _____

_____ Code _____

Telephone (W) _____ Fax (Work) _____

Telephone (H) _____ Fax (Home) _____

Cell _____ E-mail _____

Communication Preferencel Post ☐ Fax ☐ E-mail ☐

SECTION C: PARTICULARS OF CLAIM BY CESSIONARY

Bank or Institution Name _____

Title _____ Initials _____ Gender ☐ First Names _____

Surname _____ Amount Claimed _____

_____ _____

Signature of Claimant Date

SECTION D: BANK DETAILS OF CLAIMANT

Name of Bank _____ Branch Name _____

Branch Code _____ Account No _____

Name of Account Holder _____ Account Type _____

_____ _____

Signature of Account Holder Date

SECTION E: DECLARATION AND AUTHORISATION BY THE CLAIMANT

Policy Number _____ ID _____

Declaration

I, _____ (full names), declare that to the best of my knowledge all the information that I have given in this claim form is accurate and complete and that I have not withheld any information which could influence the decision on this claim. I further declare that I understand that my failure to disclose relevant information in respect of this claim may invalidate the claim.

I acknowledge that I fully understand the contents of this declaration.

Authorisation

I hereby authorise 1Life or any of its representatives to obtain any information regarding this policy from any doctor, insurer or elsewhere that may be necessary to investigate this claim. I further authorise 1Life or any of its representatives to release any information regarding this claim to any other interested parties that it deems necessary in respect of this claim.

Signed at _____ on this day _____ of 20_____

_____

Signature of Claimant(s)

Unique ID