



C L A I M F O R M

Policy No. Issue Date

Policy Type: Funeral Finance Plan Life Time Needs

Sales Rep:

Deceased's Details

First Name

Surname DOB

Postal Address

Relationship on Policy Underline as appropriate

Main Life Spouse Father Mother Mother-In-Law
Father-In-Law Son Daughter Sibling Grandparent

Employment Details of Deceased

Organisation _____

Occupation _____

Death Description

Date of Death _____ Cause of Death type _____

Place of Death _____ Exact Cause of Death _____

Aids-related Death (Y/N)?

Death Event Evidence

Death Certificate Death Certificate No. Med. Report

Police Report Post mortem report other

Medical Details

Hospital Name _____

Doctor's Name _____ Contact No. _____

Claimants Details

Name of Claimant _____

Employers of claimant _____

Identification received? Cell NO. _____ Office No. _____

Home no. _____ Email Address: _____

Postal Address

Banking Details of Claimant

Bank Name _____ Bank Branch Name _____

Bank Account No. _____

Declaration

I further declare that the above statements and answers to above questions are true and full, that I have withheld no material information and that I undertake to furnish any documentation, which may be required by ELAC. I expressly waive all provisions of law, custom or professional etiquette forbidding any physician or other person who attended or examined the deceased, or any institution in which the deceased received treatment, to disclose any knowledge or information which was thereby acquired and I authorise all such persons or agencies to furnish any information in their possession to ELAC.

Signature of Notifier

Date
