DEATH CLAIM FORM

Policy No:

Dear Valued Client

Please accept our condolences for your loss. We need you to complete the claim form and send it back with all the relevant documentation requested to **claims@oneplan.co.za**, or fax. **086 716 7431**. Only once we have received a fully completed form will we be able to assess the incident being claimed for.
Completion of this form by the Insured or an Insured Person or his/her mandated representative, does not in any way limit liability. Any cost incurred in completion of this form will be the responsibility of the Insured or Beneficiary.

BENEFICIERY DETAILS

Title: Initial/s: Surname:

First Name: Gender: M F

Maiden Name: Language:

ID No: Date of Birth: Y Y Y Y M M D D Policy No:

Cell No: Home Phone: Work Phone:

Physical Address:

Postal Code:

Postal Address:

Postal Code:

BANKING DETAILS OF BENEFICIARY

Bank: Account No:

Brunch Code: Account Holder:

Brunch Name: Account Type:

DEATH CLAIM

Date of Death: Y Y Y Y M M D D Place of Death:

CAUSE OF DEATH

Natural death due to disease, operation or age: Specify Cause:

Unnatural death due to accident or injury: Specify Cause:

REPATRIATION

Name of funeral services: | Contact No:

Place where remains are kept: | Place of burial:

NO	THE FOLLOWING INFORMATION MUST BE PROVIDED AS AND WHEN IT BECOMES AVAILABLE	OFFICE USE
A	A certified copy of the death certificate	
B	A certified copy of the deceased's ID	
C	A certified copy of the Beneficiary's ID	
D	Proof of bank account of the Beneficiary	
E	Proof of residence of the Beneficiary	
F	Quotation for repatriation (if applicable)	

I, the undersigned there by give instructions to the Underwriter, to pay any benefits to the nominated account. I further give a mandate to One card Management Services (Pty) Ltd to act on my behalf and instruct One card Management Services (Pty) Ltd to instruct payment as request and mandated by me. I agree that the cover for repatriation will be paid directly to the relevant service provider.

Signed by the beneficiary who authorized to claim on this _____ day of _____ 20 ____ at _____

Signature: _____ Name & Surname: _____

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ANNEXURE A UNNATURALLY DEATH CLAIM FORM

DECEASED

Full name of deceased: | Policy No:

TICK THE RELEVANT CAUSE OF DEATH

	✓
Assault as an innocent bystander	
Assault incident provocked by the insured deceased	
Assault when on duty	
Motor vehicle accident, insured deceased was a passenger	
Motor vehicle accident, insured deceased was a pedestrian	
Motor vehicle accident, insured deceased was a driver	
Possible Suicide deceased	
Shooting accident	
Shooting due to the insured deceased taking his/her own life	

GIVE A DETAILED DESCRIPTION OF HOW THE INCIDENT HAPPENED

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INVESTIGATING OFFICER'S REPORT

Date of Death: Y Y Y Y M M D D Time of Death: Place of Death:

Who identified the deceased: Date of Death: Y Y Y Y M M D D

This person's relationship to the deceased:

In the event of a motor vehicle accident that the insured deceased was the driver, confirm that the insured was in possession of a valid driver's licence.

Driver's license code:

Date issued: Y Y Y Y M M D D Valid until: Y Y Y Y M M D D Was a blood alcohol test done on the driver: Y N

If yes, what was the result? (Please attach a copy of the test result)

Police case Reference No:

Name of Investigating Officer: Contact No:

Name of eye-witness: Contact No:

Full names and surname of third party involved: Contact No:

AUTOPSY DETAILS

Date of autopsy: Y Y Y Y M M D D Name of doctor who perfomed the autopsy:

Death Registration No: Y Y Y Y M M D D Cause of death, determined by autopsy:

Serial number of medical certificate:

POLICE STAMP

Signature of investigating officer

Date: Y Y Y Y M M D D

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