

FUNERAL CLAIM FORM

One form per claim

Call Centre 0861 001 788 | E-mail: info@nhb.co.za



Authorised Financial Services Provider
FSP#11314

1. POLICYHOLDER INFORMATION

- | | | |
|---|--|--|
| <input type="checkbox"/> Affidavit declaring relationship to the Deceased | <input type="checkbox"/> Certified copy of death certificate | <input type="checkbox"/> Copy BI-1663 |
| <input type="checkbox"/> Certified copy of Deceased's identity document | <input type="checkbox"/> Certified copy of Beneficiary's identity document | <input type="checkbox"/> Copy of latest payslip (only if policy is paid via persal or payroll) |
| <input type="checkbox"/> Police Report (in the event of Accidental Death) | <input type="checkbox"/> Stamped bank statement | |

2. DETAILS OF POLICYHOLDER

Name	<input type="text"/>	Surname	<input type="text"/>
ID Number	<input type="text"/>	Policy Number	<input type="text"/>
Tel No (H)	<input type="text"/>	Date of Birth	<input type="text"/>
Fax No	<input type="text"/>	Tel No (W)	<input type="text"/>
Postal Address	<input type="text"/>	Cell No	<input type="text"/>
	<input type="text"/>	Email Address	<input type="text"/>
	<input type="text"/>	Code	<input type="text"/>

3. DETAILS OF DECEASED

Name	<input type="text"/>	Surname	<input type="text"/>
ID Number	<input type="text"/>	Date of Birth	<input type="text"/>
Date of death	<input type="text"/>	Cause of death	<input type="text"/>
Relationship	<input type="checkbox"/> Principal <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Extended <input type="checkbox"/> Other		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female		

4. DETAILS OF BENEFICIARY

Name	<input type="text"/>	Surname	<input type="text"/>
ID Number	<input type="text"/>	Date of Birth	<input type="text"/>
Tel No (home)	<input type="text"/>	Relationship to Deceased	<input type="text"/>
Cell No	<input type="text"/>		

5. BENEFIT PAYMENT DETAILS OF BENEFICIARY - PROOF OF BANKING DETAILS MUST BE ATTACHED

Name of Account Holder	<input type="text"/>
Name of Bank	<input type="text"/>
Account Number	<input type="text"/>
Branch Name	<input type="text"/>
Type of Account	<input type="checkbox"/> Cheque <input type="checkbox"/> Savings <input type="checkbox"/> Transmission <input type="checkbox"/>
Branch Code	<input type="text"/>

6. AIRTIME OR GROCERY NOMINATED TELEPHONE NUMBER - IN THE EVENT OF A VALID CLAIM

Select one ☐ Airtime ☐ Grocery Voucher

Airtime Benefit or Grocery Voucher will be transferred to the Cellphone Number as nominated by you if this service is applicable on your policy. The number provided must not be a contracted number.

Cellphone Number

7. IMPORTANT NOTIFICATION

Claims will only be paid if:

- 1) Premiums are paid in accordance with the terms & conditions.
- 2) All documents required are submitted with a duly completed claim form;
- 3) All waiting periods in terms of the policy provisions have been completed;
- 4) The claim is made in good faith.

ASSUPOL / NHB may use personal information about you, as defined in the Protection of Personal Information Act, that ASSUPOL / NHB lawfully obtained in the past or may obtain in the future, including the information provided to ASSUPOL / NHB for this form, for the following reasons:

- 1) To consider claims;
- 2) For all purposes of administration of such policies, issued in the past or in the future, particularly to consider claims for benefits and to trace persons who could benefit from the policies;
- 3) To market ASSUPOL / NHB and their associates' products and services.

X

Full name of Policyholder / Beneficiary

Signature of Policyholder / Beneficiary

Date

8. IF APPLICABLE, COMPLETE THIRD PARTY MANDATE AND INDEMNITY

I, the Policyholder / Beneficiary of (policy number) , do hereby expressly authorise Assupol / NHB, to pay the claim value to I indemnify Assupol / NHB against any claim whatsoever arising out of, or in connection with, this Third Party Payment instruction. I will assume personal liability for any claim, loss and / or damage of whatever nature which Assupol / NHB may suffer as a result of this Third Party Payment instruction.

I, the undersigned do hereby declare that I have read and understood the standard terms and conditions as well as any declaration and amendment hereto. I hereby indemnify ASSUPOL / NHB against all losses or damage, which they may sustain, as a result of transactions.

I acknowledge in my personal capacity and in my capacity as representative / beneficiary of the deceased, hereby indemnify NHB against any claim made by any person, pursuant to any benefit paid by the Scheme.

Signed at (place) _____ this _____ day of _____ 20 _____
transactions entered into on the basis of this delegation of authority by myself to

X

Full name of Policyholder / Beneficiary

Policyholder / Beneficiary Signature

Date