CLAIMS APPLICATION & DISCHARGE
HOLLARD FUNERAL PLAN

FAX -	COMPLETED & SIGNED DOCUMENTS TO (011)351-3003	OR
EMAIL -	TO lifeclaimsadmin@hollard.co.za	OR
POST ORIGINALS -	LIFE CLAIMS – PO Box 87428 – Houghton - 2041	

SECTION 1	VALIDATION AND CONFIRMATION

I, _____ , the claimant on this policy, confirm that I have (i) Read, (ii) understand, (iii) agree, (iv) and will adhere to the requirements noted as **Section 1,** which is outlined on the original faxed cover sheet submitted to me by HOLLARD, which lists the requirements of the claim.

(Note that the first page of the fax is not to be faxed with the claim form and required documents. Should you not agree to any of the noted points, please highlight and circle the specified number. E.g. "i", "ii", "iii" or "iv" and submit a reason signed in the presence of a Commissioner of Oaths.)

	SECTION 2	CONTRACT INFORMATION
	SCHEME NAME	
Signature of Claimant	POLICY NUMBER	

INFORMATION OF THE POLICY HOLDER			
SURNAME			
FULL NAMES			
ID NUMBER			
SECTION 3	**INFORMATION OF DECEASED / LATE**		
SURNAME			
FULL NAMES			
ID NUMBER			
RESIDENTIAL ADDRESS OF LATE		POSTAL ADDRESS OF LATE	
POSTAL CODE		POSTAL CODE	
TELEPHONIC AND ELECTRONIC CONTACT INFORMATION	WORK		
	HOME		
	CELL		
	EMAIL		
SECTION 4	**INFORMATION OF EMPLOYMENT PRIOR TO DEATH OF THE LATE**		
NAME OF EMPLOYER/ SCHOOL			
TELEPHONE NUMBER			
FAX NUMBER			
ADDRESS OF EMPLOYER/ SCHOOL			
SECTION 5	**INFORMATION ON DEATH OF THE INSURED / LATE**		
DATE OF DEATH			
CAUSE OF DEATH (Please give full details)			
INFORMATION OF FUNERAL PARLOUR THAT CONDUCTED THE FUNERAL			
NAME OF FUNERAL PARLOUR			
ADDRESS OF PARLOUR			
CONTACT PERSON AT PARLOUR			
TEL NO.		DATE OF FUNERAL	

POLICY NUMBER			
SECTION 6	**INFORMATION OF CLAIMANT**		
SURNAME			
FULL NAMES			
ID NUMBER			
RESIDENTIAL ADDRESS OF CLAIMANT		**POSTAL ADDRESS OF CLAIMANT**	
POSTAL CODE		**POSTAL CODE**	
TELEPHONIC AND ELECTRONIC CONTACT INFORMATION	**WORK**		
	HOME		
	CELL		
	EMAIL		
RELATION TO LATE		**OCCUPATION**	
ADDRESS OF EMPLOYER			
SECTION 7	**INFORMATION OF TRIBAL AUTHORITY**		
NAME OF TRIBAL CHIEF / HEADMAN			
ADDRESS			
TELEPHONE NUMBER			
SECTION 8	**PAYMENT / ELECTRONIC TRANSER VALIDATION REQUEST**		
NAME OF BANK		**BRANCH NAME**	
ACCOUNT NUMBER		**BRANCH CODE**	
ACC HOLDER ID NUMBER		**ACCOUNT TYPE**	
ACCOUNT HOLDER FULL NAME			
ACC HOLDER TEL NUMBER			

SIGNATURE OF CLAIMANT		**DATE**	

SIGNATURE OF ACC HOLDER		**DATE**	

SECTION 9	**CONSENT TO GAIN ACCESS TO, SHARE AND RECEIVE INFORMATION**

I, _____ the claimant hereby notify Hollard Life Assurance Company of the death of _____ and state that all the information furnished by me are true and complete.

A. In the event that this claim or any supporting documents is found to be false and or dishonest, Hollard Life reserves the right to proceed with legal action against me or any other parties involved.
B. It is important for insurance companies to share claims, insurance underwriting and Financial Information in order to enable the fair assessment and underwriting of risks and to reduce the number of insurance fraud.
C. On my behalf and on the behalf of any person I represent herein, I hereby consent to the sharing of private insurance underwriting, financial claims and medical condition information and or records.
D. The information provided in respect of the claim and policy may be verified against other sources of information or databases.
E. I hereby irrevocably authorize any Medical Practitioner, hospital or any other person to disclose and or hand over to Hollard Life, or it's representatives, any details, records and or documents relating to treatment and or illness, injury or general information relevant to the claim or such information as may be necessary or required to consider this claim.

SIGNATURE OF CLAIMANT		**DATE**	

WITNESS DETAILS	**NAME AND SURNAME**	
	ID NUMBER	
	WORK TEL NUMBER	
	CELL NUMBER	
SIGNATURE OF WITNESS	**DATE**	