FAMILY FUNERAL DEATH CLAIM FORM

Sanlam

BASIC REQUIREMENTS

- ☐ Original or Certified copy of Death Certificate
- ☐ Or Medical Certificate of the Cause of Death
- ☐ The Deceased's NRC
- ☐ Policy Document
- ☐ Burial Permit
- ☐ Latest Payslip of Premium Payer
- ☐ Police Report (If Unnatural Death)
- ☐ Proof of Age if ID is incorrect

Note: Sanlam reserves the right to request any additional documentation it deems necessary to verify the claim. If sufficient proof of death has not been submitted, this may lead to delays in the payment of the claim.

Policy Number:			Main Life Assured:						
Benefit Type:	Main Life Assured		Spouse		Child		Parent		Wider Family	
Relationship To Policy Holder:									

TO BE COMPLETED BY THE CLAIMANT (OR PERSON SO AUTHORISED)

1. PARTICULARS OF THE DECEASED

TICK BOX

First Name(s)		Male	
Surname		Female	
Place of Birth		Date of Birth	
NRC No.			
*Address of deceased:			
Telephone Number:			
*Occupation:			
Employer (or School if student):			
Work (School Address) Address:			
Telephone Number:			
Exact Cause of Death:		*Date of Death:	
*Place of Death:			
When was the Policy accepted by Sanlam?		Date:	

***Denotes Compulsory Field**

2. PARTICULARS OF CLAIMANT

TICK BOX

First Name(s)		Male	
Surname		Female	
NRC No.		Date of Birth	
Residential Address:			
Occupation:		Employer	
Work Address:			
Telephone Number:			

3. HOW WOULD YOU LIKE PREMIUM BEING PAID FOR THE DECEASED TO BE TREATED, PLEASE TICK YOUR OPTION: BEING PAID FOR THE DECEASED TO BE TREATED, PLEASE TICK YOUR OPTION:

Delete Premium ☐ Take Premium into Investment Account Disability & Dread Disease ☐ Add another Life ☐

NB: Premium can only be deleted subject to the minimum premium requirement on the policy. If adding another life complete part C of page 4 of this form.

4. PAYMENT DETAILS

Account Number:	
Name of Bank and Branch:	

5. DECLARATION

I/We further declare that the above statements and answers to the above questions are true and full, that I/We have withheld no material information and that I/We undertake to furnish any documentation which may be required by Sanlam. I/We expressly waive all provisions of law, custom or professional etiquette forbidding any physician or other person who knew or attended or examined the deceased, or any institution in which the deceased was known or 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 Sanlam.

1.	3.
2.	4.

Signature(s) of claimant(s)		Witnesses	
Date:		Date:	

REMARKS BY BRANCH REPRESENTATIVE:

Names:	Date:	Signature:

OFFICE USE (STRICTLY CLAIMS OFFICIALS)

DOCUMENTS SUBMITTED

- ☐ Death Certificate
- ☐ Proof of Bank NC
- ☐ Pay slip
- ☐ Deceased I.D
- ☐ Birth Certificate
- ☐ Claimant I.D
- ☐ Marriage Certificate
- ☐ Affidavit

Completed by: _____ Date: _____

PREMIUM PAYMENT

Monthly Premium: K _____ Payor _____

Month First Premium Paid: _____ Month Last Premium Paid: _____

Does the deceased's age match with that on Policy?:

Amount of outstanding Premium (see part B on page 4 overleaf): K _____

Remarks

Completed by: _____ Date: _____

First Signatory: I have verified and approved this claim.

Signature: _____

Date: _____

First Signatory: I have verified and approved this claim.

Signature: _____

Date: _____

CLAIM DISCHARGE

Cheque No. _____ Amount: K _____

Claimants Signature on collection of cheque: _____ Date: _____

Thumb Print:

OUR SERVICE STANDARD

On receipt of the full documentation, we will immediately pay the whole benefit, or a portion thereof, at any of our Customer Service Centres or at our head office, provided the beneficiaries or claimant (s) is/are entitled to receive the proceeds and sufficient verification has been obtained to confirm that the insured event has occurred.

Making a Better Life Possible .....For You

PART B

CALCULATION OF OUTSTANDING PREMIUM:

a) Escalation Amount:			
No. of months		Amount Due: K	
b) Monthly Premium Amount:			
No. of months		Amount Due: K	
c) Monthly Premium Underpayment: K			
No. of months		Amount Due: K	
d) Total Premiums outstanding (a+b+c): K			

PART C

The Customer Services Manager

Sanlam House, Corner of Lubuto and Lungwebungu Roads,

Plot 1278 Rhodespark, Lusaka

PO Box 31991 Lusaka

Dear Sir/Madam,

RE: POLICY CHANGES

Please make the following changes to my policy ZM1V

Additions	Surname	First Name	Date of Birth	Relationship
1.				
2.				
3.				
4.				

Deletions	Surname	First Name	Date of Birth	Relationship
1.				
2.				
3.				
4.				

Signed: Date: