

FAMILY FUNERAL DEATH CLAIM FORM



BASIC REQUIREMENTS

- | | | | |
|--------------------------|---|--------------------------|------------------------------------|
| <input type="checkbox"/> | Original or Certified copy of Death Certificate | <input type="checkbox"/> | Burial Permit |
| <input type="checkbox"/> | Or Medical Certificate of the Cause of Death | <input type="checkbox"/> | Latest Payslip of Premium Payer |
| <input type="checkbox"/> | The Deceased's NRC | <input type="checkbox"/> | Police Report (If Unnatural Death) |
| <input type="checkbox"/> | Policy Document | <input type="checkbox"/> | 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:	<input type="text"/>	Main Life Assured:	<input type="text"/>			
Benefit Type:	<input type="checkbox"/> Main Life Assured	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	<input type="checkbox"/> Wider Family	<input type="checkbox"/>
Relationship To Policy Holder:	<input type="text"/>					

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

1. PARTICULARS OF THE DECEASED

TICK BOX

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

*Denotes Compulsory Field

2. PARTICULARS OF CLAIMANT

TICK BOX

First Name(s)	<input type="text"/>	Male	<input type="checkbox"/>
Surname	<input type="text"/>	Female	<input type="checkbox"/>
NRC No.	<input type="text"/>	Date of Birth	<input type="text"/>
Residential Address:	<input type="text"/>		
Occupation:	<input type="text"/>	Employer	<input type="checkbox"/>
Work Address:	<input type="text"/>		
Telephone Number:	<input type="text"/>		

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

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Death Certificate | <input type="checkbox"/> Pay slip | <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Marriage Certificate |
| <input type="checkbox"/> Proof of Bank NC | <input type="checkbox"/> Deceased I.D | <input type="checkbox"/> Claimant I.D | <input type="checkbox"/> 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: <input type="text"/>	I have verified and approved this claim.	First Signatory: <input type="text"/>	I have verified and approved this claim.
Signature: <input type="text"/>		Signature: <input type="text"/>	
Date: <input type="text"/>		Date: <input type="text"/>	

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 Life Insurance Zambia Limited
P.O. Box 31991
Lusaka

Dear Sir/Madam,

RE: POLICY CHANGES

Please make the following changes to my policy ZM

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: