HEALTHCOR PROJECTS SINCE 1988

Healthcor Projects (Pty) Ltd is an Authorised Financial Services Provider, No. 17862

BARGAINING COUNCIL BCCCI CONTRACT CLEANING SERVICES INDUSTRY KZN

FAMILY *CRISIS PLAN*

DEATH AND FUNERAL CLAIM FORM

This form MUST be completed and returned to **Healthcor Projects (Pty) Ltd.**
Leli fomu KUFANELWE ligcwaliswe bese libuyiselwa kwa **Healthcor Projects (Pty) Ltd.**

Please send this completed form with all relevant documentation to **queries@healthcorsa.co.za**
For assistance please call Healthcor Projects (Pty) Ltd on 064 922 8489 or 083 278 4680

This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership.

PERSONAL PARTICULARS (PRINCIPAL MEMBER)

COMPANY NAME		POLICY NUMBER	
SURNAME		FIRST NAMES	
ID OR PASSPORT NO.			
DATE OF BIRTH	D D M M Y Y Y Y		
COMPANY BRANCH		COMPANY SITE	

PERSONAL PARTICULARS (OF CLAIMANT)

SURNAME		FIRST NAMES	
ID OR PASSPORT NO.			
DATE OF BIRTH	D D M M Y Y Y Y		
TELEPHONE NUMBER	CODE	CELLPHONE NUMBER	CODE
WORK NUMBER	CODE		

POSTAL ADDRESS	PHYSICAL ADDRESS (IF DIFFERENT)
POSTAL CODE	POSTAL CODE

PARTICULARS OF DECEASED

SURNAME		FIRST NAMES	
ID OR PASSPORT NO.			
DATE OF BIRTH	D D M M Y Y Y Y		
GENDER	☐ MALE ☐ FEMALE	RELATIONSHIP TO MEMBER	☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

IS THIS CLAIM IN RESPECT OF A DEPENDANT CHILD OVER THE AGE OF 21? ☐ YES ☐ NO

IF YES, PLEASE ATTACH DETAILS OF THE SCHOOL, COLLEGE OR UNIVERSITY ATTENDED BY THE PATIENT AND/OR PROOF THAT THE CHILD WAS TOTALLY DEPENDANT ON THE PRINCIPAL MEMBER.

DETAILS OF CLAIM

TYPE	☐ NATURAL DEATH	☐ ACCIDENTAL DEATH
EXACT CAUSE OF DEATH		
DATE OF DEATH	D D M M Y Y Y Y	
PLACE OF DEATH		
FUNERAL PARLOUR		

PAYMENT INSTRUCTIONS

ACCOUNT HOLDER'S NAME			
BANK / BUILDING SOCIETY		ACCOUNT TYPE	☐ CURRENT
ACCOUNT NUMBER			☐ TRANSMISSION
BRANCH CODE			☐ SAVINGS

CAPACITY

DATE D D M M Y Y Y Y

SIGNATURE OF ACCOUNT HOLDER

NOTE:

Benefit amount payable to nominated beneficiary's account only. No third party payments allowed. Ambledown Financial Services will not be liable for the loss of funds due to the provision of incorrect bank details by the member.

DECLARATION BY CLAIMANT

1. I hereby declare that the person mentioned under claim details is nominated under the abovementioned policy, that all the particulars given are true and complete, and that his / her / my incapacitating condition was not wholly or partly, directly or indirectly caused by the contingencies mentioned in the exclusions of the policy in question.
2. I further declare that the above statements and answers to the questions under the relevant sections are true and completed in full, that I/we have not withheld any material information and that I/we undertake to furnish any documentation which may be required by the Insurer. I expressly waive all provisions of law, custom or professional etiquette forbidding any physician or any other person attended or examined the deceased or any institution in which the deceased received treatment to disclose any knowledge or information which was thereby acquired and I/we authorise all such persons or agencies to furnish any information in their possession to the Insurer or its authorised representative.
3. I hereby authorise any hospital, physician or other person who has attended or examined the deceased to furnish to, Guardrisk Life Limited (FSP 76), or its authorised representative, any information with respect to any illness or injury medical history consultation prescriptions or treatment and copies of all hospital or medical records.
4. I consent to Ambledown or its authorised representatives from obtaining and processing my and the deceased's personal information and I understand why my /their personal information is required and the purpose it will be used.
5. I acknowledge I have the right to request from Ambledown details of any of my personal information Ambledown holds on my behalf and details of how my personal information has been processed and to lodge a complaint with the Information Regulator.

DATE D D M M Y Y Y Y

SIGNATURE

PRINCIPAL MEMBER / NOMINATED BENEFICIARY / EXECUTOR OF DECEASED ESTATE (NAME/SURNAME)

PLEASE ATTACH

- ☐ Fully completed and claim form
- ☐ Certified ID / birth certificate copies - deceased and claimant
- ☐ Certified copy of death certificate
- ☐ A letter from the funeral parlour, on a formal letterhead, confirming that the body is in their care
- ☐ BI-1663 form / death registration form
- ☐ Accident / Police report (for accidental death claims only)
- ☐ Stamped copy of claimant's bank statement
- ☐ In the case of a dependant child over the age of 21, please attach details of the school, college or university attended by the deceased

DATE D D M M Y Y Y Y

SIGNATURE OF CLAIMANT

Broker Details: Healthcor Projects (Pty) Ltd. FSP Number: 17862
Tel: 064 922 8489/ 083 278 4680 PO B ox 1735, Umhlanga Rocks, 4320