



Claim Application & Discharge

The following documentation is required:

- A fully completed claim form;
- A certified copy of the Identity Document of the deceased Assured Person;
- A certified copy of the Death Certificate of the deceased Assured Person;
- A certified copy of the Identity Document of the Claimant (If not Company);
- A copy of the form BI 1663
- A copy of the form BI 14 (Burial Order) when requested by SIA
- If a stillborn child, a letter from the doctor confirming the length of pregnancy;
- Every accidental death claim will require a police report;
- In the case of a Spouse, marriage certificate or an affidavit satisfactory to Insurer;
- In the case of a legitimate biological child, a certified copy of the Participant's or Spouses Identity Document and marriage certificate and child's birth certificate;
- In the case of a stepchild, a certified copy of the relevant marriage certificate and the Child's birth certificate;
- In the case of an illegitimate or adopted child, a copy of the adoption certificate, and affidavit or any other documentary proof satisfactory to the Insurer;
- All copies shall be certified by a Commissioner of Oaths and originally certified copies to be sent to the Insurer.
- Original signed copy of the Policy document/Application form (preferably the first month of sign up)
- If the claim payout is being made to a funeral home in order for them to render funeral services, then an invoice or quotation for these services must be submitted.

Please complete all details required on both pages.

Incomplete details may cause delays and be requested again later.

Claimant Details/Funeral Home Details (as per Policy Document)

Claimant's Full Names		Claimant's Surname		Date of Birth	
Identity No.		Employer			
Tel. (H)		Tel. (W)			
Street Address					
			Postal Code		
Postal Address					
			Postal Code		
Relationship to Deceased					

Deceased Details

Scheme Name		Policy No.			
Deceased Full Names		Deceased Surname		Date of Birth	
Identity No.		Main Members Name			
Tel. (H)		Tel. (W)			

Street Address			
		Postal Code	

Details of Death

Date of Death		Place of Death		Cause of Death	
Police Case No.		Police Station		Hospital Admission No.	
Date of Funeral		Burial Cemetery			
Name of Undertaker			Undertakers Address		
Undertakers Tel. No.					
Certifying Doctor			Doctors Address		
Doctors Contact No's.					

Other Applicable Information

Payment Details & Indemnity

In my capacity of claimant, I the undersigned acknowledge that all details provided are correct, and that I am the valid recipient of any benefit payment. I further understand that any misstatement or non-disclosure which materially affects the assessment of this claim, may cause settlement of the claim to be declined or delayed

I request payment be made as follows:

Full Payment To:

Signature: _____ **Date:** _____

Bank Details

Bank		Branch		Branch Code	
Acc. No.		Acc. Holder		Acc. Type	

Should you have any questions with regard to the completion of this form, please contact the claims department.

Contact No's	082 241 4949 / 011 507 4777
Fax. No	011 507 4700 / 086 670 2654