DEATH BENEFIT CLAIM FORM

Please return to: Hollard Group Risk, 1st Floor, 34 Melrose Boulevard, Melrose Arch or PO Box 87419, Houghton 2041
Tel: (011) 351 5000. Fax: (011) 351 3262. Email : riskclaims@cinpf1.co.za

SECTION A: HOW TO CLAIM

It is essential that this form is fully completed to prevent any unnecessary delays due to missing or incomplete information. This form should be completed by the policyholder. If we ask for an original certified copy of a document we will not accept a certified copy of a previously certified copy.

This form is structured in eight sections:

- Section A: How to claim (informative section)
- Section B: Policy details
- Section C: Employer's details
- Section D: Deceased's personal details
- Section E: General details
- Section F: Claim details
- Section G: Declaration

This fully completed form should be accompanied by the following supporting documentation:

- an original certified copy of the insured's death certificate
- an original certified copy of the insured's identity document
- three copies of the insured's payslips, two of the months prior and one in the month of the event
- a copy of the completed BI-1663 report
- a copy of the accident report form from the South African Police Service

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Life.

PRIVACY

We respect the confidentiality of your personal information as well as your privacy. If necessary, we may need to share your personal information with third parties. These third parties are other insurance and/or reinsurance companies, or service providers that may assist us in assessing and managing the risk,or servicing you. We impose the same strict confidentiality standards on these parties as is applied by us. By providing the required personal information and signing this, you hereby confirm that you consent to us processing and sharing your personal information with third parties. We will treat this information with caution, and we have put reasonable security measures in place to protect it. The information provided will only be used for its intended purpose and will not be shared with Hollard Group or another organisation for marketing additional products and/or services.

SECTION B: POLICY DETAILS

Employer: ☐

Policyholder: ☐

Policy number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Membership / Employee number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

SECTION C: EMPLOYER'S DETAILS

Name of company:

Physical address:

Code:

Postal address:

Code:

Contact person:

Job title:

Telephone number:

Fax number:

Email address:

SECTION D: DECEASED'S PERSONAL DETAILS

First names:

Surname:

Identity number:

Date of birth: DDMMYYYY

Gender: M F

SECTION E: GENERAL DETAILS

Month for which the last risk premium was paid: MMYYYY

Was the deceased at work on date of death: Y N

If "No" please give the date when the deceased was last at work and the reason for absence: DDMMYYYY

Salary for the month prior to date of death:

Has the deceased been employed in any territory outside the SADC region? Y N

(SADC region means the Southern African Development Community comprising Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, the Republic of South Africa, Swaziland, Tanzania, Zambia and Zimbabwe)

If "Yes" please provide details, including period of employment:

SECTION F: CLAIM DETAILS

Date of death: DDMMYYYY

Cause of death:

If death is a result of an accident please answer the questions below:

The accident occurred at (place):

On (date): DDMMYYYY At (time): hhmm h

Name of Police Station where accident was reported:

The SA Police case number:

Describe fully how the accident happened:

SECTION G: DECLARATION

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from the Fund and its insurance partners. In the event that this claim or any supporting claim documentation is found to be fraudulent, the Fund and its insurance partners reserves the right to proceed with the appropriate action against the claimant.

I authorise the insurer to make payment to the designated CINPF bank account and I acknowledge that payment of the benefits claimed, shall release the fund from all liability in respect of such benefits.

I have read, understand and agree to the privacy statement in this form which includes the collection and processing of personal information. If I am agreeing to the aforementioned on behalf of someone else, I confirm that I have the necessary approval and/or mandate to do so.

I authorise any medical practitioner, hospital or other person to provide the fund with any information they may require relating to the deceased's medical history and/or injury including accident and police reports, which may be necessary for the fund's consideration of the claim.

Signed at on this day of 20

Name and Surname of authorised signatory who warrants his/her authority to sign on behalf of the policyholder:

Please include an electronic signature (if available):

Identity Number of authorised signatory:

Designation of authorised signatory:

Telephone number of authorised signatory:

Email address of authorised signatory:

Company stamp:

Hollard is committed to "Creating and securing a better future" and therefore subscribes to an internal Anti-Fraud policy. Please report any suspicious or unethical activity anonymously on 0801 516 170 (toll free) or via email at Hollard@tip-offs.com.