3 IRENE STREET, BELLVILLE, 7530, PO BOX/POSBUS 1513, BELLVILLE, 7535
TEL (021) 946 2519, FAX (021) 946 2193

NU ERA DEATH CLAIM FORM

IMPORTANT:

Please attach original certified copies of the following documents:
Identify Document (ID) of claimant and deceased, Death Certificate (BI-5) and Notification of Death (BI-1663). If deceased is a dependant child aged 21 - 26, please attach proof of disability or proof of full-time studies. If deceased is a dependant child aged over 26, please attach proof of disability.

NB: All fields must be completed

SCHEME DETAILS

Scheme Name

Scheme Number

PRINCIPAL MEMBER DETAILS

Surname

First name(s)

ID number

Date of Birth D D M M Y Y Y Y

Policy No.

Cover Amount , Category

Entry Date D D M M Y Y Y Y

Old Entry Date D D M M Y Y Y Y

DECEASED'S DETAILS

Deceased's Membership Type (please tick one) Member ☐ Spouse ☐ Adult Dependant ☐ Stillborn child ☐ Child (<21 yrs) ☐
Child (21-26 yrs) ☐ Child (>26 yrs) ☐

Surname

First name(s)

ID number

Date of Birth D D M M Y Y Y Y

Date of Death D D M M Y Y Y Y Proof of death attached: Death Certificate ☐ Notification of Death ☐

Cause of death (please tick one) Natural ☐ Stillborn ☐ Suicide ☐ Unnatural ☐ Under Investigation ☐

List other documents attached: _____

DETAILS OF THE PERSON CLAIMING

Surname

First name(s)

ID number

Relationship to

Telephone number No.

Cellphone number

Email address

Street address

Postal Code

Postal address

Postal Code

REQUEST TO PAY A BENEFIT TO SOMEONE OTHER THAN THE BENEFICIARY

I,

with identity number The original beneficiary of the above deceased, authorise

NU ERA FUND ADMINISTRATORS

(the Receiver) to receive the benefits that are due to me. The Receiver, may handle the claim on my behalf, and collect the benefits from Safrican on my behalf.

I authorise GROUP SCHEME ("the Group Scheme")

to receive the benefits due to me. They will handle the claim and collect the benefits from Nu Era. The Group Scheme will settle any payments and if there is any excess they will give it to me. I cannot hold Safrican responsible for this, as the arrangement is between the Group Scheme and myself. Should the Receiver not pay the remainder of the funds to me, I know and understand that I will not have a claim against Safrican for the shortfall, as the arrangement for the payment is between the Receiver and the Group Scheme.

Signature Date D D M M Y Y Y Y

BANKING DETAILS OF THE BENEFICIARY/RECEIVER

Name of account holder

Bank name

Branch Name

Branch Code

Account number

Account type ☐ Cheque

Claim amount

Street address

Postal Code

POLICY CONTINUATION / CANCELLATION INSTRUCTION

Continue with Policy ☐ Cancel Policy ☐ Transfer Policy ☐

Main member Deceased Transfer Policy to:

Spouse: ☐

Child (18 yrs & Older): ☐

Surname

First name(s)

Full ID number

DECLARATION BY CLAIMANT

I declare that I have not withheld any information or documents that Safrican needs to consider in order to finalise the claim. This form has been completed fully and correctly. Everything in it is true, and I understand and agree with it. I authorise, Safrican to get information and documents that are necessary and sufficient to consider and finalise this claim from other persons and entities - including medical practioners, hospitals, other insurers, credit bureaus, previous or present employers and any public official or body. I authorise all such other persons and entities to provide such information and documents to Safrican, if needed. I understand my claim can be delayed if more information or documents are requested and not received by Safrican.

Signature

Date D D M M Y Y Y Y

Signature of Guardian
(if a child is under the age of 18)

Date D D M M Y Y Y Y

OFFICE USE ONLY

1. Claim Number
2. Payment Bank Code
3. Payment Date D D M M Y Y Y Y

Underwritten By:

safrican
Live the Legacy
A Subsidiary of Sanlam