CLAIM FORM
(Funeral)

Completed and signed documents
should be returned to:
claims@ukheshe.co.za
or contact (010) 444 0040 for assistance

To be completed by the claimant

POLICYHOLDER DETAILS

Policy number: _____

Full names: _____

Surname: _____

ID number: _____

MAIN MEMBER'S DETAILS

First names: _____

Surname: _____

ID number: _____

Physical address: _____

Postal address: _____

Email address: _____

Landline number: _____Cell phone number: _____

CLAIMANT'S DETAILS

First names: _____

Surname: _____

ID number: _____

Relationship to the deceased: _____

Email address: _____

Landline number: _____ Cell phone number: _____

DETAILS OF THE DECEASED

First names: _____

Surname: _____

ID number: _____

Physical address: _____

Date of death: _____

Cause of death: _____

Place of death (e.g. hospital, clinic, at home): _____

If at hospital or clinic, please provide name of facility: _____

Address of facility: _____

Phone number of facility: _____

Date of funeral: _____

Name of funeral parlour: _____

Address of funeral parlour: _____

Phone number of funeral parlour: _____

Name of doctor that certified the death: _____

Address of doctor: _____

Phone number of doctor: _____

PAYMENT INSTRUCTIONS

Account Holders name: _____

Name of bank: _____

Name of branch: _____

Branch code: _____ Account Number: _____

Type of Account: Current: _____ Savings: _____

SUPPORTING DOCUMENTATION REQUIRED

The following documents must be submitted with the claim form:

1. Certified copy of death certificate.

2. Certified copy of insured person's ID
3. Certified copy of the beneficiary's ID

4. Completed funeral claim form
5. DHA1663 – notification of death register
6. Claimant/Beneficiary 1 month bank statement

7. Police report if unnatural death

Further information may be requested at our discretion.

DECLARATION

I , ……...the claimant hereby notify uKheshe Payment Solutions of the death of the life insured and declare that the above answers and full statements are true to the best of my knowledge and belief and that I have withheld no material fact from the company.

I declare that the information given is true and complete to the best of my knowledge and belief and authorise any hospital, physician or other person who has attended to the patient to furnish uKheshe Payment Solutions, or persons acting on behalf of uKheshe, any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital records, including the results of all tests undergone by the patient. I agree that a photocopy of this authorisation shall be considered as effective and as valid as the original.

Claimant Name: _____

Claimant Signature: _____

Date: _____