CLAIM FORM
(Life)

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: _____

CLAIMANT DETAILS

Full names: _____

Surname: _____

Date of birth: _____

ID number: _____

Relationship to the life insured: _____

Physical address: _____

_____

Postal address: _____

_____

Email address: _____

Landline number: _____

Cell phone number: _____

In what capacity or by what title do you claim the insurance benefits: _____

_____

DETAILS OF THE LIFE ASSURED

Date of death: _____

Cause of death: _____

Name of employer at date of death: _____

Address of employer: _____

Telephone number of employer: _____

Occupation at time of death: _____

Previous occupation: _____

NATURAL DEATH (complete if the life insured died due to an illness)

a) When did the health of the deceased first begin to be affected? (if known): _____

b) When did the deceased first consult a doctor for his/her illness? (if known): _____

c) Did the deceased use tobacco in any form and/or did the deceased consume alcohol? _____

UNNATURAL DEATH (complete if the life insured died due to an accident)

a) When did the event occur? Date (DDMMYY) and Time: _____

b) Where did the event occur? _____

c) If a road accident, please supply address of the police station to which the accident was reported and case number:
_____
_____

d) If possible, please give full details on the nature of the injuries sustained by the deceased: _____

_____

e) Was the death caused by suicide, self-inflicted injury or transgressing any law or as a result thereof? _____

f) Was the death caused by participating in a war or hazardous activities? _____

MEDICAL PRACTITIONER AND MEDICAL AID DETAILS

Name and address of the deceased's usual family doctor (if known): _____

_____

_____

Name and address of all doctors who attended to the deceased during the last five years preceeding his death (if known):

Date of illness/injury	Duration of illness/injury	Nature of illness/injury	Doctor or institution	Telephone No.

a) Name of deceased's medical aid society at the time of death: _____

_____

b) Medical aid membership number: _____

Did the deceased have insurance with any other company? Please give details.

Name of Company	Insured Amount	Policy Inception Date

Was the estate of the deceased insolvent at the time of death? _____

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 medical report

If the insured person dies within the first 2 years of the policy, extra documentation may be needed, such as:

1. Police report / statement completed by the police

2. Copy of the post-mortem report and result of any forensic laboratory investigations
3. Inquest findings or full verdict in the case of a murder (if appropriate)

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.

Title: _____ First names: _____

Surname: _____

Account Holders name: _____

Name of bank: _____

Name of branch: _____

Branch code: _____ Account Number: _____

Type of Account: Current: _____ Savings: _____

Signature_____ Date:_____