OLDMUTUAL

GROUP ASSURANCE
FAMILY COVER BENEFIT CLAIM FORM

Insurance Contract underwritten by Old Mutual

GUIDELINES FOR COMPLETING THIS FORM

1. Complete the application form fully and in detail as it gives us important information.
2. Use the checklist below to ensure you provide us with all the necessary documents.
3. If you are a beneficiary and wish to deal with Old Mutual directly about your claim or require assistance, please contact us using the details below.

SCHEME DETAILS

Scheme name _____ Scheme code _____

Employer name _____

EMPLOYEE DETAILS

First name(s) _____

Surname _____

Identity number _____ Date of birth D D M M Y Y Y Y

Date of joining employer D D M M Y Y Y Y Date of joining scheme D D M M Y Y Y Y

REQUIREMENTS

Please indicate who the deceased is and send us the documents that are ticked for the relevant deceased person in the table below:

Employee ☐ Spouse/Child ☐

DOCUMENTS REQUIRED	DECEASED IS AN EMPLOYEE	DECEASED IS AN INSURED SPOUSE/ CHILD
Copy of death certificate, certified by a Commissioner of Oaths (If a handwritten abridged death certificate is submitted, this must be accompanied by a letter from the Department of Home Affairs with the reason why a handwritten abridged death certificate was provided)	✔	✔
Notification of death/stillbirth form - all 3 pages (DHA 1663/BI 1663)	✔	✔
Police report for unnatural/accidental deaths	✔	✔
Certified copy of employee's identity document	✔	✔
Employee's latest payslip	✔	✔
Completed Family Cover Benefit Claim Form (this form)	Section 1 only	Section 2 only
Completed Beneficiary Nomination Form for family cover benefits	✔	Not required
Beneficiary's bank statement and certified copy of identity document	✔	Not required
Employee's bank statement	Not required	✔
Certified copy of the insured spouse's identity document/insured child's unabridged birth certificate	Not required	✔
Proof of relationship of the spouse/child to the employee: **Spouse:** • Certified copy of marriage certificate, or • Declaration from a third party confirming the duration of the relationship, on a formal letterhead, signed and stamped, e.g. Traditional Leader, Minister of religion, and • Employer records, Beneficiary Nomination Form or Medical Scheme Nomination Form **Child:** • If biological or stepchild: affidavit from the other parent/third party confirming the relationship between the child and the employee, or • If adopted child: adoption/guardianship letter from the High Court or SASSA grant letter, or, • If child is stillborn: letter from the doctor/hospital confirming the gestational age of foetus • Employer records, Beneficiary Nomination Form or Medical Scheme Nomination Form	Only required if payment is to be made to surviving family member (see section 1)	✔

***Please note that if you are submitting a claim for extended family benefits:**

- Provide the requirements listed above for insured spouse/child, and the Extended Family Nomination Form
- Complete section 2.

You are welcome to contact us at 021 509 4351 should you require assistance with completing and submitting this form.

Submit the form by email, fax or post:

Email	gapdeathclaims@oldmutual.com
Fax	021 509 4669
Address	Death Claims Team (6J) Old Mutual PO Box 2386 Cape Town 8000

A NOTE TO BENEFICIARIES

Please indicate whether you consent to Old Mutual:

☐ communicating with the policy holder, OR

☐ communicating with you directly, using the details provided below:

First name(s) _____

Surname _____

Email address _____

Cellphone number _____

PROTECTION OF PERSONAL INFORMATION DISCLOSURE

The Old Mutual Group may use, share or obtain personal information (including criminal and/or health information) for the following purposes:

- Underwriting
- Assessment and processing of claims
- Where applicable, credit reference searches or verification, credit scoring and assessment and credit management
- Verification of personal information (including identity, address and banking details)
- Updating member/lives assured personal information
- Claims checks (Industry Life and Claims Register(s))
- Tracing beneficiaries
- Tracing you where you are uncontactable
- Prevention and detection of fraud, crime, money laundering (including anti-money laundering screening) or other malpractice
- Market or customer satisfaction research or statistical analysis
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements and in connection with legal proceedings
- Sharing information with service providers we engage to process such information on our behalf or who render services to us. These service providers may be abroad, but we will not share your information with them unless we are satisfied that they have adequate security measures in place to protect personal information.

You agree that Old Mutual may view, search and update your information.

All members/beneficiaries may access their personal information that we hold and may also, under certain circumstances, request us to correct any errors or to delete this information. In certain cases they have the right to object to the processing of their personal information.

You also have the right to complain to the Information Regulator, whose contact details are:
Website: www.justice.gov.za/inforeg/index.html
General enquiries: enquiries@inforegulator.org.za
Complaints: POPIAComplaints@inforegulator.org.za

To view our full privacy notice and to exercise your preferences, please visit our website on www.oldmutual.co.za/privacy-policy/

EMPLOYER/CLAIMANT DECLARATION

I, _____ the undersigned, in my capacity as _____ and duly authorised to make this declaration, hereby declare:

a) That the information provided in this claim is true and correct, and that no information has been omitted or withheld
b) That the insured person whose death gave rise to this claim has in fact died
c) That payment of the proceeds, due in respect of the above insured person in terms of the aforementioned policy, shall represent the full and final discharge of Old Mutual Group Assurance's liability in respect of this insured person

I indemnify Old Mutual Group Assurance against any claim that may arise from any incorrect information provided in this form.

Signed at _____ on this _____ day of _____ 20

Full name _____

Designation/Relationship to employee _____

Cellphone number _____

Email address _____

Signature _____

1 ONLY COMPLETE IF THE DECEASED IS THE EMPLOYEE

DETAILS OF EMPLOYEE'S DEATH

Date of death D D M M Y Y Y Y

Main cause of death

BENEFICIARY DETAILS

Please select ONE option below:

a) The most current nomination form for group family benefits has been attached to this claim application ☐

b) If no nomination form can be located from the deceased, please select one option below:

- There is no surviving family member (this benefit will be paid into the deceased's estate) ☐
- There is a surviving family member (either surviving spouse, child over the age of 18/legal guardian of minor child, parent, brother or sister). Please provide details below. ☐

First name(s)

Surname

Identity number

Relationship to the employee

Email address

Cellphone number

PAYMENT DETAILS

Please provide the account details of the beneficiary on the nomination form; OR the next of kin; OR the deceased's Estate according to the option selected above.

Account holder's name

Bank name

Account number

Branch/SWIFT code

2 ONLY COMPLETE IF THE DECEASED IS AN INSURED SPOUSE OR CHILD

INSURED SPOUSE OR CHILD DETAILS

First name(s)

Surname

Identity number

Date of birth D D M M Y Y Y Y

Relationship to the employee

Date of death D D M M Y Y Y Y

Main cause of death

If deceased is stillborn, please provide gestational age of foetus weeks

PAYMENT DETAILS

Please provide the bank details of the employee below:

Account holder's name

Bank name

Account number

Branch/SWIFT code

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