



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.

SCHEME DETAILS

Scheme name Scheme code

Employer name

EMPLOYEE DETAILS

First name(s)

Surname

Identity number Date of birth

Date of joining employer Date of joining scheme

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 Insured spouse

DOCUMENTS REQUIRED	DECEASED IS AN EMPLOYEE	DECEASED IS AN INSURED SPOUSE
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 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 Group Life Benefit Claim Form (this form)	Section 1 only	Section 2 only
Completed Beneficiary Nomination Form for group life benefits (only for employer-owned/unapproved benefits)	✓	Not required
Nominated beneficiary's bank statement and certified copy of identity document	✓	Not required
Employee's bank statement	Not required	✓
Certified copy of insured spouse's identity document	Not required	✓
Proof of relationship of the spouse to the employee: <ul style="list-style-type: none"> • Certified copy of marriage certificate, or if not available • 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 	Not required	✓

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

Submit the form via 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 your 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 your identity, address and banking details)
- Updating your 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 your 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

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ONLY COMPLETE IF THE DECEASED IS THE EMPLOYEE

DETAILS OF EMPLOYEE'S DEATH

Date of death

D	D	M	M	Y	Y	Y	Y
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Main cause of death

BENEFICIARY AND PAYMENT DETAILS

1. Fund owned policies: Benefits will be paid to the Fund OR2. Employer owned policies: In terms of the Insurance Act, Old Mutual is required to pay this benefit to the beneficiary selected by the deceased. If no beneficiary has been provided in a nomination form, this benefit must be paid to the deceased's Estate. Please select **ONE** option below:2.1 **No nomination form can be located from the deceased (this benefit will be paid into the deceased's Estate)**

Bank account details of deceased estate

Account holder's name

Bank name

Account number

Branch/SWIFT code

2.2 **The most current nomination form for group life benefits has been attached to this claim application.**

- Please complete the table below with the details of the nominated beneficiaries as per the beneficiary nomination form
- If there are more beneficiaries, please attach additional copies of page 5
- The allocated percentage of benefits should total 100%

NOMINATED BENEFICIARY DETAILS AS PER THE BENEFICIARY NOMINATION FORM

BENEFICIARY 1

Allocated percentage of benefit %

First name(s)

Surname

Identity number

Bank account details

Account holder's name

Bank name

Account number

Beneficiary contact information for confirmation of payment

Email address

Cellphone number

BENEFICIARY 2Allocated percentage of benefit %First name(s) Surname Identity number **Bank account details**Account holder's name Bank name Account number **Beneficiary contact information for confirmation of payment**Email address Cellphone number **BENEFICIARY 3**Allocated percentage of benefit %First name(s) Surname Identity number **Bank account details**Account holder's name Bank name Account number **Beneficiary contact information for confirmation of payment**Email address Cellphone number **BENEFICIARY 4**Allocated percentage of benefit %First name(s) Surname Identity number **Bank account details**Account holder's name Bank name Account number **Beneficiary contact information for confirmation of payment**Email address Cellphone number

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ONLY COMPLETE IF THE DECEASED IS THE INSURED SPOUSE

INSURED SPOUSE'S DETAILS

First name(s)	<input type="text"/>
Surname	<input type="text"/>
Identity number	<input type="text"/>
Date of birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Marital regime with employee	<input type="checkbox"/> Civil Marriage <input type="checkbox"/> Civil Union <input type="checkbox"/> Customary marriage <input type="checkbox"/> Life Partner <input type="checkbox"/> Other <input type="text"/>
Date of death	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Main cause of death	<input type="text"/>

PAYMENT DETAILS

Employer owned policies: This benefit will be paid to the employee.

EMPLOYEE'S BANKING DETAILS

Account holder's name	<input type="text"/>
Bank name	<input type="text"/>
Account number	<input type="text"/>
Branch/SWIFT code	<input type="text"/>

