



## 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	<input type="text"/>	Scheme code	<input type="text"/>
Employer name	<input type="text"/>		

## EMPLOYEE DETAILS

First name(s)	<input type="text"/>						
Surname	<input type="text"/>						
Identity number	<input type="text"/>	Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of joining employer	<input type="text"/>	Date of joining scheme	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## 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"> <li>• Certified copy of marriage certificate, or if not available</li> <li>• 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</li> <li>• Employer records, Beneficiary nomination form or Medical scheme nomination form</li> </ul>	Not required	✓

**You are welcome to contact us at 0860 20 30 40 should you require assistance with completing and submitting this form.**

**Submit the form via email, fax or post:**

Email            superfundfunerals@oldmutual.com  
 Fax                021 509 4677 or 021 509 6271  
 Address          Old Mutual SuperFund  
                       PO Box 728  
                       Cape Town  
                       8000  
                       South Africa.

## 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 personal information received by Old Mutual in accordance with this contract will be used, as and when appropriate, for the following purposes:

- Underwriting
- Assessment and processing of claims
- Claims checks (Life and Claims Register)
- Fraud prevention and detection
- Tracing beneficiaries
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements
- Verification of the personal information provided

Personal Information will be de-identified when used for market research and statistical analysis.

When Old Mutual engages service providers to process personal information on its behalf or to render services to it, Old Mutual may share some personal information with these service providers, subject to confidentiality agreements being in place between Old Mutual and such service providers. Should these service providers be abroad, Old Mutual will not share the personal information with them unless it is satisfied that adequate security measures are in place to protect the personal information.

The Policyholder is advised and encouraged to inform all members/lives assured that Old Mutual holds and is processing their personal information for the purposes noted above. The Policyholder or a member/life assured may access the personal information relating to him or her and, subject to the provisions this contract may request the correction of any errors or the deletion of this information. In certain cases the Policyholder and members/lives assured have the right to object to the processing of their personal information.

The Policyholder or members/lives assured have the right to complain to the Information Regulator, whose contact details are:

**Website**        justice.gov.za/infocreg/index.html

**Telephone**    012 406 4818

**Fax**             086 500 3351

**Email**          infocreg@justice.gov.za

Old Mutual's full privacy notice can be viewed at [www.oldmutual.co.za/privacy-policy/](http://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
---	---	---	---	---	---	---	---

Main cause of death

## BENEFICIARY AND PAYMENT DETAILS

1. Fund owned policies: Benefits will be paid to the Fund  OR

2. 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 2**

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 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"/>

