

DEATH CLAIM FORM

Please return Claim Forms to:

1. **Fax to**
(011) 351-3003
2. **Post Originals to:**
Life Claims
P O Box 87428
HOUGHTON 2041



TO BE COMPLETED BY THE PERSONAL MEDICAL ATTENDANT

DETAILS OF LIFE ASSURED

Policy number

Surname.....

Full names.....

Date of Birth.....

I.D. number (please submit proof).....

DETAILS OF THE DEATH OF THE LIFE ASSURED

Date and time of death (DDMMYY).....

Place of death.....

Age at death.....

1. Immediate cause of death
.....
2. If (1) arises from illness, please answer this question and ignore question number 3.
(a) Date of its commencement (DDMMYY).....
(b) Date when deceased first became aware of it or any symptoms (DDMMYY).....
3. If (1) arises from an accident please answer this question and ignore question number 2.
(a) When did you first attend to the deceased with regard to injuries sustained in the accident ?
.....
(b) Please give full details of the nature of the injuries sustained by the deceased.
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.....
4. (a) Are you the usual medical attendant of the patient. If so, how long have you known him/her?
.....
.....

(b) If no, please supply the name, address and telephone number of the usual medical attendant and telephone number if available that consulted the deceased during the past 5 years.
.....
.....
.....Postal Code.....

Administered by;



5. (a) Please state any diseases or conditions which preceded or co-existed with the immediate cause of death.

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(b) Dates of commencement (DDMMYY)

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.....

(c) State fully if any of the following contributed or predisposed to the cause of death

Previous illness/injury

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Family History

.....

Habits

.....

6. (a) Nature of any other complaints for which the deceased consulted you

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.....
.....

(b) Dates of consultations (DDMMYY)

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.....

(c) Is there any reason to believe that the life assured's death is in any way due to or arises directly or indirectly, entirely or partially, from AIDS or HIV infection? If yes, please give full details.

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(d) Has the deceased ever been tested for HIV antibodies? If yes, what was the result of the test?

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7. Nature of complaints and dates of consultations.

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DECLARATION

8. Did the deceased consume any alcohol? If yes, please state amount per week

9. Did the deceased use tobacco in any form?

10. Was an inquest or post mortem inquiry held?.....

11. Please state any other relevant facts

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I declare that I have personally attended the patient and that all the foregoing statements are correct to the best of my knowledge.

Name Qualifications

Date Signature

Practise No SAMDC No.

Postal Address

.....

.....Postal Code

Telephone number (.....) Cell No.....