

Please return Claim Forms to:

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



RETRENCHMENT/REDUNDANCY CLAIM FORM

TO BE COMPLETED IN FULL

Company Name

Physical Address.....

..... Postal Code.....

Telephone Number..... Facsimile..... e-mail address

COMPANY DECLARATION

We hereby state that the staff member(s) named below have been retrenched/made redundant by the company with effect from the

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We also certify that the staff member(s) named below have not taken voluntary retrenchment, early retirement, been dismissed or have resigned. They were on full time employment and not on contract or part time employees.

EMPLOYEE NUMBER	DATE FIRST EMPLOYED	NAME	ID NUMBER OR DATE OF BIRTH

We hereby declare and warrant that the statement above is, to the best of our knowledge, true and correct and that no information has been withheld or relevant circumstances omitted.

Signature.....

Company Stamp

Name and title (Please print).....

On thisday of.....year.....

Administered by;

