MHA
Authorised Financial Services Provider
FSP#10134

FUNERAL CLAIM FORM

One form per claim

Call Centre 0861 001 788

NHB
Authorised Financial Services Provider
FSP#11314

1. POLICYHOLDER INFORMATION

- ☐ Affidavit declaring relationship to the Deceased
- ☐ Certified copy of Deceased's identity document
- ☐ Police Report (in the event of Accidental Death)
- ☐ Certified copy of death certificate
- ☐ Certified copy of Beneficiary's identity document
- ☐ Stamped bank statement
- ☐ Copy BI-1663
- ☐ Copy of latest payslip (only if policy is paid via persal or payroll)

2. DETAILS OF POLICYHOLDER

Name | Surname

ID Number | Policy Number

Tel No (H) | Date of Birth (D D / M M / Y Y Y Y)

Fax No | Tel No (W) | Cell No

Postal Address | Email Address

Code

3. DETAILS OF DECEASED

Name | Surname

ID Number | Date of Birth (D D / M M / Y Y Y Y)

Date of death (D D / M M / Y Y Y Y) | Cause of death

Relationship ☐ Principal ☐ Spouse ☐ Child ☐ Parent ☐ Extended Other

Gender ☐ Male ☐ Female

4. DETAILS OF BENEFICIARY

Name | Surname

ID Number | Date of Birth (D D / M M / Y Y Y Y)

Tel No (home) | Relationship to Deceased

Cell No

Postal Address | Code

5. BENEFIT PAYMENT DETAILS OF BENEFICIARY - PROOF OF BANKING DETAILS MUST BE ATTACHED

Name of Account Holder

Name of Bank: FNB | ABSA | NEDBANK | STD BANK | BIDVEST | CAPITEC | OTHER

Account Number

Branch Name | Branch Code

Type of Account: Cheque (X) Savings (X) Transmission (X)

6. AIRTIME NOMINATED TELEPHONE NUMBER - IN THE EVENT OF A VALID CLAIM

Airtime Benefit will be transferred to the Cellphone Number as nominated by you if this service is applicable on your policy.

The number provided must not be a contracted number.

Network Provider

Cellphone Number | Airtime Amount R

7. IMPORTANT NOTIFICATION

Claims will only be paid if:

1) Premiums are paid in accordance with the terms & conditions.

2) All documents required are submitted with a duly completed claim form;

3) All waiting periods in terms of the policy provisions have been completed;

4) The claim is made in good faith.

ASSUPOL / MHA / NHB may use personal information about you, as defined in the Protection of Personal Information Act, that ASSUPOL / MHA / NHB lawfully obtained in the past or may obtain in the future, including the information provided to ASSUPOL / MHA / NHB for this form, for the following reasons:

1) To consider claims;
2) For all purposes of administration of such policies, issued in the past or in the future, particularly to consider claims for benefits and to trace persons who could benefit from the policies;
3) To market ASSUPOL / MHA / NHB and their associates' products and services.

X		
Full name of Policyholder / Beneficiary	Signature of Policyholder / Beneficiary	Date

MHA & NHB
8 Bedford Rd, St Andrews, Bedfordview, 2007
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www.mhasa.co.za / www.nhb.co.za

Authorised Financial Services Provider FSP#53
Products underwritten by Assupol Life Limited ASSUPOL

8. IF APPLICABLE, COMPLETE THIRD PARTY MANDATE AND INDEMNITY

I, the Policyholder / Beneficiary of _____ (policy number) , do hereby expressly authorise Assupol / MHA / NHB, to pay the claim value to _____ I indemnify Assupol / MHA / NHB against any claim whatsoever arising out of, or in connection with, this Third Party Payment instruction. I will assume personal liability for any claim, loss and / or damage of whatever nature which Assupol / MHA / NHB may suffer as a result of this Third Party Payment instruction.

I, the undersigned _____ do hereby declare that I have read and understood the standard terms and conditions as well as any declaration and amendment hereto. I hereby indemnify ASSUPOL / MHA / NHB against all losses or damage, which they may sustain, as a result of transactions.

I acknowledge in my personal capacity and in my capacity as representative / beneficiary of the deceased, hereby indemnify MHA / NHB against any claim made by any person, persuant to any benefit paid by the Scheme.

Signed at (place)_____ this_____ day of _____ 20 _____
transactions entered into on the basis of this delegation of authority by myself to _____

	X	
Full name of Policyholder / Beneficiary	Policyholder / Beneficiary Signature	Date