Dear Sir / Madam

Please find attached a Death Claim Form/s for your attention.

Please attach the following documents to the completed form:

1. **Certified** copy of Death Certificate.
2. **Certified** copy of Identity Document of deceased.
3. Copy of Divorce order (If applicable)
4. Copy of Marriage Certificate (If applicable)
5. Copy of payslip as at date of death.
6. **Certified** copy of Identity document of beneficiaries (If minor, **certified** copy of school certificate and **certified** birth certificate)
7. Proof of bank details of beneficiaries/nominee (personal bank statement/confirmation letter)
8. **NB.** Tax Ref Number must be completed irrespective of income. Please contact **SARS** on 0800 007277.
9. BI -1663 form (Notification of death)

Forms to be completed:

Verso Fund Administration Form -Benefit claim form

Verso Fund Administration Form - Disposal of Death benefits

Verso Death Claim Financial Needs Analysis (to be completed by **all** major beneficiaries/nominees/guardians)

Police Report for assessment of death claim (to be completed for unnatural deaths)

Affidavit/s (to be completed by **all** major beneficiaries/nominees/guardians)

Hollard - Death benefit claim form (only when the death benefit is applicable)

You can email the completed claim forms with all required documents to hbsipension@prevue.co.za

Please make sure the pages are clear and readable.
(**No Pictures or Links will be allowed, only scanned PDF documents)**

If you have any questions, please contact us.

Kind regards,

National HBSI Pension Fund

Tel no: +27 86 111 4662

Cell : +27 72 858 9786

Email : hbsipension@prevue.co.za

VERSO®
FINANCIAL SERVICES (PTY) LTD
An authorised Financial Services Provider

Belmont Office Park, Twist Street, Bellville, 7530
P.O. Box 4300, Tyger Valley, 7536
Tel: 021 943 5300
Fax: 021 917 4601
E-mail: info@verso.co.za
Web: www.verso.co.za

BENEFIT CLAIM FORM

FUND NAME _____

TO BE COMPLETED BY THE MEMBER

MEMBER DETAILS

MEMBER NO. _____ EMPLOYEE NO. _____

SURNAME _____ FIRST NAMES _____

DATE OF BIRTH _____ IDENTITY NUMBER _____

GENDER: MALE ☐ FEMALE ☐ MARITAL STATUS _____

RESIDENTIAL ADDRESS _____

_____

POSTAL ADDRESS _____

_____

(Both of the above addresses are required by the SA Revenue Services - SARS)

TEL NO. (_____)_____ CELL PHONE NO. _____

E-MAIL ADDRESS _____

PREFERRED LANGUAGE FOR CORRESPONDENCE: ☐ ENGLISH ☐ AFRIKAANS

INCOME TAX REFERENCE NO. _____ REVENUE OFFICE OF LAST TAX RETURN _____

BANKING DETAILS

(Please attach a copy of your bank statement)

ACCOUNT HOLDER'S NAME _____

BANK NAME _____ ACCOUNT NUMBER _____

BRANCH NAME _____ BRANCH CODE _____

ACCOUNT TYPE: ☐ CURRENT ☐ SAVINGS ☐ TRANSMISSION

FOREIGN ACCOUNT ☐ (Tick if applicable) COUNTRY _____

DIVORCE ORDERS

Are you aware of any Divorce Order issued by the High Court / Supreme Court against your pension benefit in favour of an ex-spouse?

☐ YES ☐ NO

If yes, attach an original certified copy of the complete divorce court order to this form (if not already supplied to the Fund). This order must be in terms of Section 7(8) of the Divorce Amendment Act 1989, to be binding on the Fund. Please provide full contact details of the ex-spouse in order for the benefit payment to be made by the Fund.

Ex-spouse Details

SURNAME _____ FIRST NAMES _____

DATE OF BIRTH _____ IDENTITY NUMBER _____

RESIDENTIAL ADDRESS _____

_____

POSTAL ADDRESS _____

_____

TEL NO. (_____)_____ CELL PHONE NO. _____

E-MAIL ADDRESS _____

BENEFIT OPTIONS (Withdrawal and Retirement Claims ONLY)

*Please refer to the **IMPORTANT NOTES** section below, before exercising an option*

☐ Leave my benefit invested in the Fund until further notice (if applicable in terms of the Rules of the fund, please refer to your Human Resources office).

☐ Pay benefit directly into my own bank account as specified above.

☐ Pay portion of my benefit into my own account as specified above. Specify amount or percentage: _____

On retirement from a Pension Fund you are entitled to commute up to a maximum of 1/3rd (33.33%) of your retirement benefit. The exception to this rule is if your retirement benefit is less than R247 500, you are then permitted to take the full retirement benefit as a lump sum.

☐ Transfer of Benefit; ☐ Full Benefit

☐ Portion of Benefit: Specify amount or percentage: _____

NAME OF FUND: _____

TYPE OF FUND: _____

CONTACT DETAILS: _____

IMPORTANT NOTES

Paid -up Membership

1. **Terms**

   As a paid-up member, you are required to preserve your entire withdrawal benefit in the Fund (i.e. you may not take any portion in cash and preserve the balance). You may access your paid-up benefit (cash and/ or transfer) at any age prior to or at retirement. No new contributions to the Fund are permitted. No deductions may be made from your member share in respect of any insured risk benefits.

   With effect from 1 March 2019, you automatically become a paid-up member in the Fund on the termination of your employment, if you ***do not choose a benefit option***. You remain a paid-up member in the Fund until you complete and submit a withdrawal claim form, instructing the Fund what you wish to do with your member share.

2. **Tax**

   You do not pay any tax when you become a paid-up member. Any future lump sum taken will be taxed on the same basis as any other lump sum payment from a fund.

3. **Investments**

   Your member share remains invested in your elected investment portfolio. You are permitted 1 free switch per year and the cost for additional switches is R350 (including VAT) per switch and will be paid from your member share. For more detail about the investment options, fees or the underlying investment portfolios, please contact the Fund's Administrator on 021 943-5330 or 021 943-5357 or send your ID number and contact number to rbc@verso.co.za and a counsellor will contact you.

4. **Communication**

   You will receive an annual benefit statement (including a confidential beneficiary nomination form), as well as a Paid-up certificate, confirming your status as a Paid-up member.

5. **Fees**

   For information on the fees payable for Paid-up membership, please contact the Fund's Administrator on 021 943-5330 or 021 943-5357 or send your ID number and contact number to rbc@verso.co.za and a counsellor will contact you.

Retirement Benefits Counselling

You have access to Retirement Benefits Counselling prior to you deciding on the payment of your Fund benefit and before your benefit is paid to you or is transferred to another approved fund. The option(s) you exercise now may have a long-term impact on your financial well-being and you are encouraged to take the necessary steps to empower yourself to make well-informed decisions. Please contact the Fund's Administrator on 021 943 5330 or 021 943 5357, if you wish to speak to a counsellor. Alternatively, you can send your contact number and ID number via e-mail to rbc@verso.co.za and a counsellor will contact you.

Deductions to be made from pension benefits

Any legitimate deductions will be made from your benefit irrespective of your option chosen. This is particularly relevant if you have an outstanding pension backed housing loan balance at the time of your exit from employment.

Financial Advice

The Fund encourages members to constantly seek financial advice on all fund matters and particularly when benefits become payable. Please note that the Fund will not pay fees or commissions to any financial advisers.

Confidentiality

The information disclosed within this document will be treated as confidential and will only be used for the purpose for which it is intended in terms of applicable legislation.

Tax Directive

Payment will only be made on receipt of a tax directive, issued by the SA Revenue Service (SARS).

DECLARATION BY MEMBER

It is hereby confirmed that:

1. The information contained herein is correct.
2. I am satisfied with the information and / or counselling that I received and the benefit options available to me were disclosed and explained in a clear and understandable language.

SIGNATURE OF MEMBER _____ DATE _____

TO BE COMPLETED BY THE EMPLOYER

EMPLOYER DETAILS

NAME OF EMPLOYER _____

TEL NO. (_____)_____ CELL PHONE NO. _____

E-MAIL ADDRESS _____

BANKING DETAILS

ACCOUNT HOLDER'S NAME _____

BANK NAME _____ ACCOUNT NUMBER _____

BRANCH NAME _____ BRANCH CODE _____

ACCOUNT TYPE: ☐ CURRENT ☐ SAVINGS ☐ TRANSMISSION

REFERENCE NUMBER _____ (if applicable)

CLAIM DETAILS

DATE OF TERMINATION OF SERVICE _____

REASON FOR TERMINATION OF SERVICE:

☐ WITHDRAWAL _____ (Resignation, Dismissal, Abscondment, Retrenchment, Transfer)

☐ RETIREMENT _____ (Voluntary Early, Compulsory Early, Normal, Late, Ill-health)

☐ DEATH

CONTRIBUTION DETAILS

FINAL MONTH IN WHICH CONTRIBUTION WAS MADE _____

AMOUNT OF FINAL CONTRIBUTION R_____ MEMBER

R_____ EMPLOYER

PRIOR CLAIM

Is there a prior claim in respect of section 37D of the Pension Funds Act? ☐ YES ☐ NO
If yes, please provide proof of the claim and employer banking details.

Housing loan guarantee by the fund to the bank (Fund's home loan facility):	R
Compensation for damage caused by the employee*:	R

*Where "Compensation for damage caused by the employee" applies, the employee and employer are required to complete the 'Acknowledgement of Liability and Agreement to Pay' form which is available for download from the website.

DECLARATION BY EMPLOYER

It is hereby confirmed and warranted:

- The employer has made every reasonable effort to inform the member that the Fund has a mandatory obligation to provide access to Retirement Benefits Counselling, before the member makes any decision regarding the options available, at termination.
- The information contained herein is correct and in particular, that the banking details provided above have been confirmed as correct;
- The employer will endeavor to take reasonable steps to ensure that the member exercises a benefit option and signs the form;
- The employer acknowledges that, where the member does not exercise a benefit option and / or sign the form, the member will automatically become a paid-up member in the fund three months after the Administrator has been informed that the member's employment was terminated.

The Employer hereby unconditionally absolves the Fund and Verso Financial Services and as necessary keeps indemnified the Fund and Verso Financial Services from and against all and any loss, damage, costs and expenses which the member, beneficiaries or any other person whatsoever, may sustain or incur, either directly or indirectly as a result of Verso Financial Services, on behalf of the Fund, relying on and using any information supplied by the Employer.

FULL NAME OF AUTHORISED OFFICIAL OF THE EMPLOYER _____

WORK TEL NO. (_____)_____ FACSIMILE NO. (_____)_____

E-MAIL ADDRESS _____

SIGNATURE OF AUTHORISED OFFICIAL OF THE EMPLOYER _____

DATE _____ EMPLOYER STAMP

SUPPORTING DOCUMENTS REQUIRED

WITHDRAWAL: Bank Statement

RETIREMENT: Proof of identity
Bank Statement

DEATH: Original certified copies of the following documents:

- Death Certificate (BI-5 or BI-20)
- Member and Spouse's Identity document
- Marriage Certificate
- Identity documents of any other dependants
- Beneficiary Nomination Form

Disposal of Death Benefits Form
Banking Details and Addresses of Dependants/Beneficiaries

DECLARATION

The information disclosed within this document will be treated as confidential and will only be used for the purpose for which it is intended in terms of applicable legislation. Verso Financial Services is committed to protecting and promoting the privacy of personal information of all data subjects as required by the Act; to give effect to the constitutional right to privacy; and to fulfill its obligations under the Act. As the privacy of our clients is important to us, we will use reasonable efforts to ensure that any personal information, (including special personal information), provided to us is processed in a secure manner. Verso Financial Services takes its responsibility seriously in respect of securing the integrity and confidentiality of all personal information in its possession or under its control and has taken appropriate and reasonable technical and organisational measures to prevent – loss of, damage to or unauthorised destruction of personal information; and unlawful collection, access to or processing of personal information. Please go to www.verso.co.za to view our privacy policy statement.

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Expect more
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Tel: +27 21 9435300 Fax: +27 21 9174600
FSP Licence No. 14985

FUND ADMINISTRATION FORM
DISPOSAL OF DEATH BENEFITS

FUND NAME _____

EMPLOYER NAME _____

MEMBER'S PERSONAL DETAILS

MEMBER NO. _____ SURNAME AND FIRST NAMES _____

DATE OF BIRTH _____ MARITAL STATUS _____

DATE OF DEATH _____ DATE EMPLOYER NOTIFIED OF DEATH _____

CAUSE OF DEATH _____

DEPENDANTS

Spouse(s) Details

Details of Spouse(s)	1st Spouse	2nd Spouse
Full Name		
Date of Birth		
Date of Marriage		
Type of Union (Civil, Customary, Asiatic, Common Law, Other)		
If, Common Law, give details of length of relationship		
Address		
Were deceased and spouse(s) living together at date of death?		
If not, to what extent was the deceased supporting the spouse?		
Does the spouse stay on his/her own or with parents?		
If living on his/her own, is accommodation owned or rented?		
Is spouse employed, if so, what is his/her monthly income?		

Partner(s) Details

Details of Partner(s)	1st Partner	2nd Partner
Full Name		
Date of Birth		
Relationship to Deceased (Fiance, Boyfriend, Girlfriend, Other)		
Address		
Give details of the length of the relationship		
Did the deceased support the person financially?		
If 'YES', please explain the extent of the support.		
Does the partner have a regular job?		
If 'YES', please provide income details and proof thereof.		

Ex-spouse(s) Details

(Please supply original certified copies of divorce order(s) and agreement(s)).

Details of Ex-spouse(s)	1st Ex-spouse	2nd Ex-spouse
Full Name		
Date of Birth		
Date of Marriage		
Type of Union (Civil, Customary, Asiatic, Common Law, Other)		
Date of Divorce		
If Common Law, give details of length of relationship		
Address		
At the date of death, was the deceased supporting the ex-spouse either voluntarily or in terms of a maintenance order/agreement?		
Monthly maintenance payment amount		
Has the ex-spouse remarried?		
If supported by deceased, please provide current income details of the ex-spouse and proof thereof.		

Minor Children
(Latest school report / education result to be attached for each child)

	Child No. 1	Child No. 2	Child No. 3	Child No. 4	Child No. 5
Name					
Date of Birth					
Relationship to deceased					
Guardian's Name					
Guardian's Address					
Relationship to Guardian					
Level of Dependency					
School / Tertiary Education					
Grade					
Full time / Part time study					

Major Children

	Child No. 1	Child No. 2	Child No. 3	Child No. 4	Child No. 5
Name					
Date of Birth					
Relationship to deceased					
Address					
Details of dependency					
Highest education qualification					
Marital Status					
Date of Marriage					
Working (Give details)					
Earning capacity					
Remarks					

Other Dependants

	No. 1	No. 2	No. 3	No. 4	No. 5
Name					
Date of Birth					
Relationship to deceased					
Address					
Details of dependency					

Nominees

	No. 1	No. 2	No. 3	No. 4	No. 5
Name					
Date of Birth					
Relationship to deceased					
Address					

Nomination Form

YES/NO _____ DATE FORM COMPLETED _____

DETAILS OF NOMINATION _____

_____

_____

FAMILY'S FINANCIAL DETAILS / SOCIAL CIRCUMSTANCES

_____

_____

_____

_____

_____

_____

_____

_____

DETAILS OF OTHER BENEFITS PAID BY ANOTHER FUND AND TO WHOM

_____

_____

_____

_____

_____

_____

_____

_____

DECLARATION BY EMPLOYER / SOCIAL WORKER

I, the undersigned, hereby certify that all particulars furnished in this form and accompanying documentation are true and correct, and that the options in terms of the Rules of the Fund have been fully explained to the member's beneficiaries.

FULL NAME _____

DESIGNATION _____

SIGNATURE _____ DATE _____

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FSP Licence No. 14985

DEATH CLAIM
FINANCIAL NEEDS ANALYSIS

NOTE: **THIS ANALYSIS WILL BE USED AS A GUIDE TO DETERMINE THE CIRCUMSTANCES OF THE GUARDIANS, DEPENDANTS AND NOMINEES AND WHAT THEIR CRITICAL NEEDS ARE**

UMBRELLA FUND / FUND NAME _____

PARTICIPATING EMPLOYER _____

DETAILS OF DECEASED

FUND MEMBERSHIP NO. _____

SURNAME _____ FIRST NAMES _____

PERSONAL DETAILS

SURNAME _____ FIRST NAMES _____

RELATIONSHIP TO DECEASED _____

HIGHEST GRADE / EDUCATIONAL QUALIFICATION ACHIEVED _____

EMPLOYMENT DETAILS

Are you employed?

- ☐ WEEKLY
- ☐ MONTHLY
- ☐ SELF-EMPLOYED
- ☐ UNEMPLOYED

Select the appropriate level of net earnings:

- ☐ R 50 – R 1000
- ☐ R 1 001 – R 5 000
- ☐ R 5 001 – R 10 000
- ☐ R 10 001 – R 20 000
- ☐ GREATER THAN R 20 001

What is your occupation and how long have you been employed? _____

If unemployed, were you supported by the deceased? ☐ YES ☐ NO

If 'YES', please state the Rand amount / the type of support: _____

EXPENDITURE DETAILS

Do you own any investments e.g. retirement annuities, unit trusts or shares? ☐ YES ☐ NO

If 'YES', please state the type of investment: _____

Do you have a financial advisor? ☐ YES ☐ NO

If 'YES', please provide details of your financial advisor: _____

_____

If 'NO', how do you intend investing this benefit? _____

_____

Do you have a bank account? ☐ YES ☐ NO If 'YES', please provide a copy of your bank statement.

Have you ever had a judgment against you for non-payment of debt? ☐ YES ☐ NO

If 'YES', please provide details: _____

Have you ever been declared insolvent or been placed under an administration order? ☐ YES ☐ NO

If 'YES', please provide details: _____

What is the largest sum of money you have ever dealt with? _____

Do you own or rent your residence? ☐ OWN ☐ RENT

If you 'OWN' your residence, what is the amount you owe on the bond? _____

Do you have a separate policy covering the settlement of this bond amount? _____

GUARDIAN'S / DEPENDANTS PERSONAL EXPENDITURE (ESTIMATED)

INCOME	
BASIC SALARY	R
MAINTENANCE	R
SOCIAL GRANTS	R
OTHER	R
TOTAL	**R**

EXPENDITURE	
BOND / RENT	R
TRANSPORT	R
RATES, WATER AND ELECTRICITY	R
SCHOOL AND EDUCATION	R
FOOD & HOUSEHOLD	R
ENTERTAINMENT	R
INSURANCE	R
HIRE PURCHASE / CLOTHING ACCOUNTS	R
MAINTENANCE	R
SAVINGS	R
GARNISHEE ORDERS	R
TOTAL	**R**

TAKE HOME PAY	**R**

DECLARATION

I hereby declare that the details provided herein are true and correct.

SIGNED AT _____ ON THIS _____ DAY OF _____ (MONTH) _____ (YEAR)

SURNAME _____ FIRST NAMES _____

SIGNATURE _____ DATE _____

WITNESS _____

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FSP Licence No. 14985

POLICE REPORT FOR ASSESSMENT OF DEATH CLAIM

NOTE: TO BE COMPLETED BY THE INVESTIGATING OFFICER AND WILL BE CONSIDERED STRICTLY CONFIDENTIAL

NAME OF POLICE STATION WHERE DEATH WAS REPORTED _____

CASE REFERENCE NO. _____ INVESTIGATING OFFICER _____

DETAILS OF DECEASED

SURNAME _____ FIRST NAMES _____

DATE OF BIRTH _____ ID NUMBER _____

DETAILS OF DEATH

DATE, TIME OF DEATH _____ PLACE OF DEATH _____

Please indicate circumstances of death (tick relevant block below):

☐ ASSAULT ☐ DRIVER ☐ MURDER

☐ MVA ☐ SUICIDE/SELF-INFLICTED ☐ UNKNOWN – STILL BEING INVESTIGATED

Please provide details/circumstances of death:

_____

_____

_____

_____

In all instances please advise who the main suspect is (provide name and surname) and whether this person is a family member or not.

_____

_____

_____

_____

Was a Post Mortem held? ☐ YES (if available please provide a copy) ☐ NO

If 'YES' please provide details i.e. results/reference etc.

_____

_____

_____

_____

AUTHORISATION

FULL NAME OF INVESTIGATING OFFICER _____

RANK OF INVESTIGATING OFFICER _____

TELEPHONE NO. (_____)_____ FACSIMILE NO. (_____)_____

SIGNATURE OF INVESTIGATING OFFICER _____

DATE _____ POLICE STATION STAMP

Please note that the statements in the affidavits must be in **full sentences.** For example:

- The deceased (name of the deceased) did not have any other children except Jack and Jill.
- The deceased (name of the deceased) did not support any children financially except Jack and Jill.
- The deceased (name of the deceased) did not have any other financial dependants except Jack, Jill and Jane.

Level of dependency can be either:

- **Partial** – the deceased **assisted** the person financially on a regular basis.
- **Full** – the deceased **supported** the person with all his/her financial needs.

AFFIDAVIT

NAME & SURNAME:			
ID NUMBER:		**TEL. NO:**	
ADDRESS:			
E-MAIL / FAX:			
I , the undersigned			
hereby declares as follows:			
What was your relationship to the deceased ?			
Did you live with the deceased ? (if yes, provide the duration of the relationship and date from which you lived together)			

If you did not live with the deceased, who lived with the deceased ?
Was the deceased in a relationship at the time of death ? (if yes, provide the person's details)
Did the deceased have any children ? (if yes, provide the children's details)
Who are both the parents of the children and who are the children's caregivers/guardians ? (if minor children)
Did the deceased pay maintenance or support any children or person financially? (if yes, provide the children's/persons names, the amount of support and attach proof)
Were you financially dependent on the deceased? (if yes, provide the level of dependency, the amount of support and attach proof)

Are you employed ? (if yes, provide employer's details, your occupation and the salary received)
Do you receive a state grant or pension? (if yes, provide the amount and the reason thereof)
What is your highest grade or qualification ?
Were there any parents or parents-in-law that the deceased supported financially? (if yes, please provide their names, the level of dependency, amount of support and examples thereof)
Are you aware of anyone else who may have been financially dependent on the deceased at the time of death? (if yes, provide the person's details).
Are there any other details you would like to disclose ?
What is your marital status ?

I know and understand the contents of this statement.

I have no objection to taking the prescribed oath.

I consider the prescribed oath binding on my conscience.

_____
DEPONENT'S SIGNATURE

I certify that the above statement was taken by me and that the deponent has acknowledge that he/she knows and understand the content of this statement. This statement was affirmed / sworn to before me and the signature was placed thereon in my presence at **place _____**
on **(date)** _____ **(time) _____.**

_____
Commissioner of Oaths

_____
Full names and surname

_____
Position/Rank

_____
Address of Business/Police Station

_____
Suburb/City/Police Station

Hollard Group Risk

DEATH BENEFIT CLAIM FORM

Please return to: Hollard Group Risk, 22 Oxford Road, Parktown, or PO Box 87428, Houghton 2041. Tel: (011) 351 5000, Fax: (011) 351 3262, email: hgradmin@hollard.co.za

SECTION A: HOW TO CLAIM

It is essential that this form is fully completed to prevent any unnecessary delays due to missing or incomplete information. This form should be completed by the policyholder. If we ask for an original certified copy of a document we will not accept a certified copy of a previously certified copy.

This form is structured in eight sections:

- Section A: How to claim (informative section)
- Section B: Scheme details
- Section C: Employer's details
- Section D: Deceased's personal details
- Section E: General details
- Section F: Claim details
- Section G: Banking and beneficiary details
- Section H: Declaration

This fully completed form should be accompanied by the following supporting documentation:

- an original certified copy of the deceased's death certificate
- an original certified copy of the deceased's identity document
- a copy of the deceased's last payslip
- proof of banking details (cancelled cheque or bank statement)
- proof of beneficiary's relationship to the deceased (e.g. marriage certificate)
- an original certified copy of the beneficiary's identity document
- a copy of the accident report form from the South African Police Service (if applicable)

Please note that the request for completion of this form in no way constitutes an admission of liability by Hollard Life.

SECTION B: SCHEME DETAILS

Employer:

Policyholder:

Policy number:

Membership / Employee number:

SECTION C: EMPLOYER'S DETAILS

Name of company:

Physical address:

Code:

Postal address:

Code:

Contact person:

Job title:

Telephone number:

Fax number:

E-mail address:

SECTION D: DECEASED'S PERSONAL DETAILS

First names:

Surname:

Identity number:

Date of birth: D D M M Y Y Y Y

Gender: M F

SECTION E: GENERAL DETAILS

Month for which the last risk contribution was paid: M M Y Y Y Y

Was the deceased at work on the date of death? Y N

If "No" please give the date when the deceased was last at work and the reason for absence: D D M M Y Y Y Y

Salary for the month prior to date of death:

Has the deceased been employed in any territory outside the SADC region? Y N

(SADC region means the Southern African Development Community comprising Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, the Republic of South Africa, Swaziland, Tanzania, Zambia and Zimbabwe)

If "Yes" please provide details, including period of employment:

SECTION F: CLAIM DETAILS

Date of death: D D M M Y Y Y Y

Cause of death:

If death is a result of an accident please answer the questions below:

The accident occurred at (place):

On (date): D D M M Y Y Y Y At (time): H H h M M

Name of Police Station where accident was reported:

The SA Police case number:

Describe fully how the accident happened:

SECTION G: BANKING DETAILS

If the death benefit is underwritten through an approved policy, payment will be made to the policyholder (the Fund) only.

If the death benefit is underwritten through an unapproved policy, payment will be made to the policyholder, or as instructed by the policyholder.

Please select to whom payment must be made: Policyholder Other

If policyholder, please provide the policyholder's banking details:

Name of account holder:

Name of Bank:

Branch:

Branch code:

Account type:

Account number:

If other, please list the beneficiaries below and provide the banking details. Note that payment is only done via EFT (electronic fund transfer) and that no third party payments are allowed – payment will only be made to the beneficiary's bank account.

Name of beneficiary A

Identity number:

Benefit %: Relationship to deceased:

Address:

Code:

Name of Bank:

Branch:

Branch code:

Account type:

Account number:

Name of beneficiary B

Identity number:

Benefit %: Relationship to deceased:

Address:

Code:

Name of Bank:

Branch:

Branch code:

Account type:

Account number:

Name of beneficiary C

Identity number:

Benefit %: Relationship to deceased:

Address:

Code:

Name of Bank:

Branch:

Branch code:

Account type:

Account number:

SECTION H: DECLARATION

I declare that the answers and statements I have made are true to the best of my knowledge and I have not withheld any material facts from Hollard Life. In the event that this claim or any supporting claim documentation is found to be fraudulent, Hollard Life reserves the right to proceed with the appropriate action against the claimant.

I authorise Hollard Life to make payment as instructed above and I acknowledge that payment by Hollard Life of the benefits claimed, shall release Hollard Life from all liability in respect of such benefits.

I authorise any medical practitioner, hospital or other person to provide Hollard Life with any information they may require relating to the deceased's medical history and/or injury, which may be necessary for Hollard Life's consideration of the claim.

Signed at _____ on this _____ day of _____ 20 _____

_____ _____

Name of authorised signatory | Designation

_____ _____

Signature
For and on behalf of the policyholder | Company stamp