Accidental Death Claim Form

(UNNATURAL DEATH)

CLAIMING

The submission of this claim does not automatically constitute an admission of liability under this policy.

This Accidental Death Claim Form is to be completed in full - please give us as much information as you can so that we can assess your claim speedily.

If you do not send us ALL supporting documents that we've asked for we can't assess the claim. If you don't give us all the documents within 30 days, the Insurer may reject your claim.

DOCUMENTS YOU MUST GIVE US

	• Copy of the BI 1663 OR DHA 1663 Form. Pages 1 to 4. This document is available from the SAPS/Mortuary/Funeral Home/Doctor/Medical Facility.
	• Copy of the Post-Mortem Report. This document is obtainable from SAPS/Mortuary.
	• Copy of the Accident Report/Incident Report including the case number. This document is available from the SAPS where the Accident/Incident was reported.

DOCUMENTS YOU MUST GIVE US IN THE EVENT OF THE DEATH OF THE POLICYHOLDER

	• Affidavit from claimant confirming the relationship to the Deceased.
	• Copy of letter of Proof of Certified Appointment as Administrator/Executor of the deceased's Estate.

DOCUMENTS THAT CAN FURTHER HELP YOUR CLAIM

	• Copy of the Insured's (deceased's) valid driver's licence. (Only where the Insured (deceased) was the driver of the motor vehicle at the time of the accident)
	• Copy of the Insured's (deceased's) Blood Alcohol Test Results/Report. (Only where the Insured (deceased) was the driver of the motor vehicle at the time of the accident)

Completed Claim Forms and All Supporting documentation can be sent via Email or upload to:

Email: tuclaims@iua.co.za

CSS: https://selfservice.iua.co.za/

THE UNLIMITED

PERSONAL DETAILS

POLICYHOLDER DETAILS

FULL NAME		SURNAME	
ID NUMBER		POLICY NUMBER	
TELEPHONE NUMBER		EMAIL ADDRESS	
CELL NUMBER			

PERSON COMPLETING THE FORM

FULL NAME		SURNAME	
ID NUMBER		POLICY NUMBER	
DATE OF BIRTH	D D M M Y Y Y Y	RELATIONSHIP TO THE DECEASED	
TELEPHONE NUMBER		EMAIL ADDRESS	
CELL NUMBER			

DETAILS OF THE DECEASED

FULL NAME		SURNAME	
ID NUMBER		PREVIOUS OCCUPATION	
DATE OF BIRTH	D D M M Y Y Y Y	OCCUPATION AT TIME OF DEATH	
DATE OF DEATH	D D M M Y Y Y Y	NAME OF EMPLOYER AT DATE OF DEATH	
		TELEPHONE NUMBER OF EMPLOYER	
CAUSE OF DEATH			

RESIDENTIAL ADDRESS	ADDRESS OF EMPLOYER
POSTAL CODE	POSTAL CODE

DETAILS OF UNNATURAL DEATH (Only to be completed in the event of Death related to Unnatural Death)

WHEN DID THE INCIDENT OCCUR?	WHERE DID THE INCIDENT OCCUR?
DATE D D M M Y Y Y Y	
TIME H H : M M	

IF A ROAD ACCIDENT, PLEASE SUPPLY ADDRESS OF THE POLICE STATION TO WHICH THE ACCIDENT WAS REPORTED AND CASE NUMBER

POLICE STATION ADDRESS	CASE NUMBER
	IF POSSIBLE, PLEASE GIVE FULL DETAILS ON THE NATURE OF THE INJURIES SUSTAINED BY THE DECEASED

WAS THE DEATH CAUSED BY SUICIDE, SELF-INFLICTED INJURY OR AN ILLEGAL ACT?

YES		IF YES, PLEASE PROVIDE US WITH DETAILS
NO		

WAS THE DEATH CAUSED BY PARTICIPATING IN ANY HAZARDOUS ACTIVITIES?

YES		IF YES, PLEASE PROVIDE US WITH DETAILS
NO		

PAYMENT INSTRUCTIONS
BANK ACCOUNT DETAILS THAT THE INSURER IS TO PAY THE BENEFIT INTO:

ACCOUNT HOLDERS NAME _____

NAME OF BANK _____

TYPE OF ACCOUNT CURRENT SAVINGS

ACCOUNT NUMBER _____

BRANCH CODE _____

FICA DECLARATION BY INSURED/CLAIMANT

The Unlimited must abide by FICA regulations. Due to these regulations we need you to answer a few questions. If you do not answer these questions, we may not be able to move forward with your claim.

In the past 12 months have you held a political position in South Africa or elsewhere, for example, a member of Parliament? _____

Do any of your family members or friends hold political positions? _____

Do you, your family or friends own or have a senior job at a Company that provides goods or services to Parliament, Cabinet or the Courts? _____

If the answer to any of the above is yes, please provide details on the position held: _____

_____

DECLARATION BY INSURED/CLAIMANT

I, the undersigned, being the Insured/Claimant:

- undertake to provide The Unlimited, the Insurer or IUA Business Solutions (Pty) Ltd (**the Companies**) with all the documents they need to assess this claim;
- confirm that all the information I have provided in this form is true and complete, and that I have not withheld any information that could impact the outcome of this claim;
- authorise the Companies to access and process all my personal information to assess the claim, including hospital and other medical records. I also authorise the Companies to process the personal (including medical) information of other people whose interests are protected by the policy (for example, my spouse or children). In this regard I, as well as my spouse if applicable, consent to the Companies processing the personal information of my children for the purposes of assessing this claim;
- authorise all the doctors and medical facilities which examined and treated me/the patient/deceased to provide all information about this claim to the Companies. In this regard, I waive all protections afforded to me by any law, custom or professional etiquette which prevent a doctor or medical facility from disclosing a patient's personal (including medical) information. I agree that this waiver shall remain in force until cancelled in writing; and
- indemnify the Companies against any and all damages, losses, claims and costs made against the Companies by people whose information I have authorised them to process, such as my spouse or adult dependants.

	Signed at:

Signature of Policyholder/Person completing the form

Date D D M M Y Y Y Y

Witness 1 Name/Surname

Witness 2 Name/Surname

THE UNLIMITED

Accident Death Claim Form
Police Report

To be completed by the Investigating Officer at the police station where the death of the deceased was reported. This certificate is required for an Unnatural Death Claim and will be kept confidential. (Please ensure that all questions are answered in full.)

Policy number

PARTICULARS OF THE DECEASED

THE DECEASED

FULL NAME		SURNAME	
ID NUMBER		OCCUPATION	

PARTICULARS OF POLICE CASE

POLICE STATION WHERE DEATH WAS REPORTED																							
TELEPHONE NUMBER																							
NAME OF INVESTIGATING OFFICER															RANK								
DATE, TIME AND PLACE OF DEATH	DATE	D	D	M	M	Y	Y	Y	Y	TIME	H	H	:	M	M								
	PLACE																						
MAGISTERIAL DISTRICT																							
CASE NUMBER																							

CAUSE OF DEATH

IS THERE ANY INDICATION THAT THE DECEASED MAY HAVE COMMITTED SUICIDE?																					YES		NO
IF YES, HOW DID THE DECEASED COMMIT SUICIDE?																							
WAS THE DECEASED INVOLVED IN A MOTOR VEHICLE ACCIDENT?																					YES		NO
DATE AND TIME OF ACCIDENT	TIME	H	H	:	M	M	DATE	D	D	M	M	Y	Y	Y	Y								
WAS THE DECEASED		THE DRIVER			A PASSENGER			A PEDESTRIAN															
DID THE VEHICLE THAT WAS INVOLVED IN THE ACCIDENT BELONG TO THE DECEASED?																					YES		NO
IF THE DECEASED WAS THE DRIVER, WAS AN ALCOHOL TEST DONE AT THE SCENE OF THE ACCIDENT?																					YES		NO
WAS AN ALCOHOL TEST DONE AT THE TIME OF THE POST-MORTEM?																					YES		NO

PLEASE ATTACH A COPY OF THE MEDICO LEGAL POST-MORTEM EXAMINATION REPORT TOGETHER WITH A COPY OF THE BLOOD/SPECIMEN ALCOHOL CONTENT REPORT.

WAS THE DECEASED INVOLVED IN AN ASSAULT?		YES		NO
WAS THE DECEASED AN INNOCENT BYSTANDER?		YES		NO

IF YOUR ANSWER IS NO, PLEASE GIVE DETAILS

DETAILS OF PLACE

LEGAL DETAILS

INQUEST

HAS AN INQUEST BEEN HELD?		YES		NO	NAME OF COURT										
WILL AN INQUEST BE HELD?		YES		NO	DATE OF INQUEST	D	D	M	M	Y	Y	Y	Y		
INQUEST REFERENCE NUMBER					INQUEST NUMBER										

CRIMINAL CHARGES

HAVE CRIMINAL PROCEEDINGS BEEN INSTITUTED?		YES		NO	NAME OF COURT										
WILL CRIMINAL PROCEEDINGS BE INSTITUTED?		YES		NO	DATE OF TRIAL	D	D	M	M	Y	Y	Y	Y		
TRIAL REFERENCE NUMBER					TRIAL NUMBER										
WHAT WAS THE CHARGE?					WHO WAS CHARGED?										

WAS A FAMILY MEMBER INVOLVED OR A SUSPECT IN THE DEATH?

IF YES, NAME OF FAMILY MEMBER

RELATIONSHIP TO THE DECEASED

PLEASE GIVE A BRIEF DESCRIPTION OF THE CIRCUMSTANCES OF DEATH

I, the undersigned, _____
hereby declare that all the information provided herein and as completed by myself is true and correct, and furthermore that no relevant information has been withheld which may impact on the outcome of this claim.

	Signed at:

Signature of Investigating Officer

Date D D M M Y Y Y Y