Natural Death Claim Form

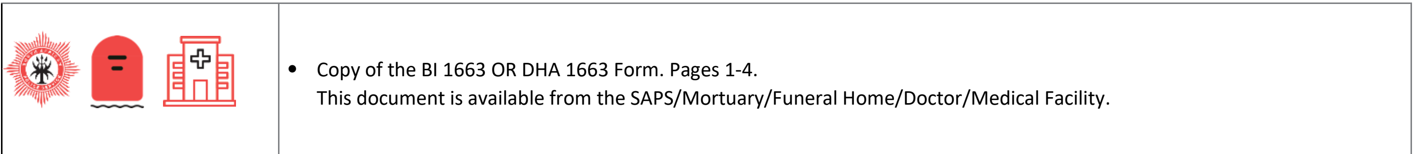
The submission of this claim does not automatically constitute an admission of liability under this policy.

This Natural Death Benefit 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 the supporting documents that we've asked for we can't assess the Claim.

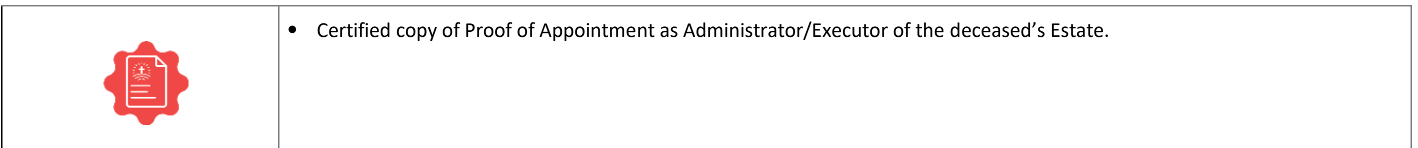
If you don't give us all the documents within 30 days, the insurer may reject your claim.

DOCUMENTS YOU MUST GIVE US:



- Copy of the BI 1663 OR DHA 1663 Form. Pages 1-4.
  This document is available from the SAPS/Mortuary/Funeral Home/Doctor/Medical Facility.

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



- Certified copy of Proof of Appointment as Administrator/Executor of the deceased's Estate.

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/

PERSONAL DETAILS

POLICYHOLDER DETAILS

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

CLAIMANT DETAILS (ONLY complete this section in the event of the death of the Policyholder)

FULL NAME		SURNAME	
ID NUMBER		POLICY NUMBER	
TELEPHONE NUMBER		EMAIL ADDRESS	
CELL NUMBER		RESIDENTIAL ADDRESS	
RELATIONSHIP TO THE POLICYHOLDER			

DETAILS OF THE DECEASED

FULL NAME		RESIDENTIAL ADDRESS
SURNAME		
ID NUMBER		
DATE OF BIRTH	D M M Y Y Y Y	
DATE OF DEATH	D M M Y Y Y Y	
CAUSE OF DEATH		
RELATIONSHIP TO THE POLICYHOLDER		

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: ______________________________

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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 stipulated supporting documents they need to assess this claim;
- confirm that all the information I have provided in this Claim Form to be true and complete, and that I have not withheld any information that could impact on the outcome of this claim;
- authorise the Companies to access and process all my personal information to assess the claim, including contacting the treating hospital/clinic and acquiring any/all supporting 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/Claimant completing the form.	Date D D M M Y Y Y Y

Witness 1 Name/Surname

Witness 2 Name/Surname