

CLAIMANT'S STATEMENT FOR RETRENCHMENT BENEFIT



SECTION A The contact person for this claim is:

Name	<input type="text"/>	Branch	<input type="text"/>
Email address	<input type="text"/>	Cellular number	<input type="text"/>
Telephone number	<input type="text"/>	Fax number	<input type="text"/>

In the event that a claimant is both the life assured and the policyholder of the policy AND is incapable of managing his/her own affairs, an appointment of a curator bonis will be required in order for Capital Legacy Solutions to further assess the claim.

NB: Claims Department will send correspondence and copies only where this information has been supplied. In other circumstances, correspondence will be directed to the Policyholder/Life Assured.

Requirements: (PLEASE COMPLETE ALL QUESTIONS)

Retrenchment Letter from Employer <input type="checkbox"/>	Copy of Life Assured's Identity Document <input type="checkbox"/>	Copy of UI-19 form <input type="checkbox"/>
Proof of beneficiaries account <input type="checkbox"/>	Latest payslip <input type="checkbox"/>	

SECTION B Life assured's details:

First name(s)	<input type="text"/>	Surname	<input type="text"/>
Policy number	<input type="text"/>	Occupation	<input type="text"/>
Highest education	<input type="text"/>	Postal address	<input type="text"/>
Residential address	<input type="text"/>		
Date of birth	<input type="text" value="DD / MM / YYYY"/>	Place of birth	<input type="text"/>

SECTION C Details regarding employment:

Company name	<input type="text"/>		
Company address	<input type="text"/>		
Date of employment	<input type="text" value="DD / MM / YYYY"/>	Date retrenched	<input type="text" value="DD / MM / YYYY"/>
Previous employer	<input type="text"/>	Years of service	<input type="text"/>

I _____ the Claimant, hereby make claim to the benefits of the above assurance policy/s and declare that the foregoing answers and statements are true to the best of my knowledge and belief, and that I have withheld no material fact from Capital Legacy Solutions.

I agree that the written statements and affidavits of all papers submitted in support of this claim shall constitute and are hereby made a part of this claim. I further agree that the supply of this form or of any other forms supplemental hereto by Capital Legacy Solutions shall not constitute an admission by it that there was any assurance in force on the life in question or a waiver of any of its rights or defense in law.

I acknowledge and agree that any benefits payable in respect of this claim shall be forfeited if I, or anyone acting on my behalf or with my knowledge and consent, have knowingly withheld any material fact or submitted any false information in respect of the claim.

I further agree that upon payment by Capital Legacy Solutions of the benefits hereby claimed, Capital Legacy Solutions shall be discharged from all liability in respect of such benefits.

Signed at _____ on this _____ day of _____ 20____

Claimant's signature	<input type="text"/>	Witness	<input type="text"/>
Claimant's email address	<input type="text"/>		

SECTION **D** Employer's declaration:

Policy number	<input type="text"/>	Identity number	<input type="text"/>
Employee full name	<input type="text"/>		
Employee number	<input type="text"/>	Date of birth	<input type="text" value="DD / MM / YYYY"/>
Name of company	<input type="text"/>	Fax number	<input type="text"/>
Email address	<input type="text"/>	Telephone number	<input type="text"/>
Date of employment	<input type="text" value="DD / MM / YYYY"/>	Termination date	<input type="text" value="DD / MM / YYYY"/>

Reason for termination, e.g. ill health/retrenchment/boarded, etc.:

I _____ hereby declare that I am the person designated and authorised by the abovementioned Company to complete and attest to this form and further confirm that all particulars provided hereto are to the best of my belief and knowledge both true and correct. I confirm that no material information, which is relevant to the assessment of this claim has been withheld, concealed or misstated.

Name	<input type="text"/>	Position	<input type="text"/>
Physical address or company stamp	<input type="text"/>		
Signature	<input type="text"/>	Date	<input type="text" value="DD / MM / YYYY"/>

Please note that in the event of any modification or variation of this standard form, Capital Legacy Solutions will regard this form as being invalid and of no force and effect. Do not sign blank or incomplete forms.