CLAIMANTS STATEMENT FOR DEATH CLAIM
(INDEMNITY PLAN™ / ESTATES OVERHEAD PROTECTOR™ / ESTATES GAP COVER™ - PLAN HOLDER)

CAPITAL LEGACY™ leave a legacy

REQUIREMENTS TO SUCCESSFULLY PROCESS THIS CLAIM:

Please take careful note of the compulsory requirements when claiming:

- DHA-1663 Notice of Death / Stillbirth form.
- Copy of Death Certificate.
- Copy of the ID document of the beneficiary.
- Proof of banking details of the beneficiary.
- Please complete all questions - do not refer to other documents.

Additional Requirements if: Death due to unnatural causes.

- Police declaration form to be completed by the investigating officer.
- In the event of an accident we also require the Accident Report (AR) Form completed at the scene

Capital Legacy Solutions reserves the right to call for additional requirements where deemed necessary.

Please note: Capital Legacy undertakes to pay this benefit within 48 hours of receipt of this claim form and the additional requirements listed above. We may however withhold payment of the benefit should reasonable additional requirements be required and you will be notified of such.

If this Policy has more than one Life Assured and the Premium Payer is deceased, please contact Capital Legacy's contact centre on 087 352 2800 (or your Financial advisor) to register the new debit order details in order to keep the remaining life's/live's cover in force.

If the first/Principal Life Assured has died and you are the second Life Assured, please confirm if you wish the Policy and its benefits to continue with you as the Plan Holder for the benefits and products that remain unclaimed.

SECTION A: WHO MUST WE CONTACT REGARDING THE CLAIM

Name:		Telephone (H):	
Telephone (W):		Cellular number:	
Email address:			

NB: Claims department will send correspondence and copies only where this information has been supplied. In other circumstances, correspondence will be directed to the beneficiaries.

SECTION B: CLAIMANT / BENEFICIARY DETAILS

Full name:			
ID number:		Contact number:	
Email address:			
Residential address:		Code	

Do you have a South African bank account? ☐ Yes ☐ No Have you officially emigrated? ☐ Yes ☐ No

Bank name:		Account type:	☐ Current ☐ Savings
Account number:		Bank Swift Code:	
Account holder:			

Please note: For Estate Gap Cover™ benefits proceeds payable to Estate

087 352 2800 | claims@capitallegacy.co.za

SECTION C: DECEASED DETAILS (PLEASE ATTACH COPY OF DEATH CERTIFICATE)

First name: Surname:

ID number: Date of death: D D M M Y Y Y Y

Immediate cause of death (please do not use natural causes, state the actual cause e.g. cancer)

Place of death:

Hospital file number: Was the death reported to police: Case Number

Name of deceased's employer at date of death:

Deceased's income per annum:

Deceased's highest education qualification attained:

Residential address: Code

Name of deceased's medical aid scheme and membership at time of death?

Did the deceased smoke tobacco in any form: Yes No

If "Yes", please give full details:

When did the health of the deceased first begin to be affected?

When did the deceased first consult a doctor for his/her last illness?

Name and address of every doctor who attended to the deceased during his/her last illness and during the five years preceding his/her death.

General Physician Name / Area / Telephone No.	Date of attendance	Reason

Specialist Name / Area / Telephone No.	Date of attendance	Reason

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SECTION D: DEATH CLAIM DECLARATION

I, in my capacity as the claimant, declare and warrant that all statements and answers which may now or at any time be given in connection with this claim, whether in my handwriting or not, are true and complete. I further understand that any misstatement or non-disclosure, which materially affects the assessment of this claim, will entitle Capital Legacy Solutions to declare this claim null and void and claim any monies for this benefit back from the Estate of the deceased.

I agree that the supply of this form or of any other forms is not an admission by you that there was any assurance in force on the life of the deceased or a waiver of any of your rights or defense in law.

I, the beneficiary of this claim hereby give Capital Legacy consent to request medical information of the deceased in order to validate the claim.

By signing this document, I confirm that I have a legal right and entitlement to claim the relevant benefits. Upon payment of the benefits, I absolve and discharge Capital Legacy Solutions, including its subsidiaries, their successors and associated companies, from any claims or further liability which may arise in relation to the policies mentioned above.

Signed at _____ on this _____ day of _____ 20 _____

Claimants signature

Witness signature

SECTION E: FINANCIAL ADVISOR'S DETAILS

Only to be completed if a financial advisor has assisted with the completion of this form.

First name:		Commission code:	
Contact number:		Signature:	

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.

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