CLAIMANT'S STATEMENT FOR RETRENCHMENT BENEFIT

SECTION A: THE CONTACT PERSON FOR THIS CLAIM

Name:

Email address:

Telephone number: Cellular number:

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

Please Note: Retrenchment benefit has a general one month waiting period from date of retrenchment.

In the event that a claimant is both the Life Assured and the Plan Holder 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 Plan Holder/Life Assured.

REQUIREMENTS: PLEASE COMPLETE ALL QUESTIONS

Retrenchment Letter from Employer: Copy of Life Assured's Identity Document: Copy of UI-19 form:

Proof of beneficiaries account: Latest payslip: If contractor copy of employment contract:

SECTION B: LIFE ASSURED'S DETAILS

First name(s): Surname:

Policy number: ID number:

Highest education: Occupation:

Residential address:

SECTION C: DETAILS REGARDING EMPLOYMENT

Current employer:

Employee number:

Previous employer:

Years of service with previous employer: Type of employment: Permanent / Contractor

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.

087 352 2800 | claims@capitallegacy.co.za

Signed at _____ on this _____ day of _____ 20 _____

Claimants email address:

Claimants signature

Witness signature

SECTION D: EMPLOYER'S DECLARATION

Manager full name:

Name of company:

Manager / HR Officer email address:

Manager / HR Officer telephone number:

Date of employment: D D M M Y Y Y Y Termination date: D D M M Y Y Y Y

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

Physical address or company stamp:

Signature: Date: D D M M Y Y Y Y

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.

087 352 2800 | claims@capitallegacy.co.za