

Claim form: Death

Form to be completed by claimant.

Once you've completed the form, please email it to claims@stangenlife.co.za; or fax it to us at 087 942 725 and our claims team will take it from there; or phone us on 010 020 7655.

Section A

Particulars of the insured (deceased)			
Policy Number			
Surname			
First Names			
Title	Miss Mrs Mr Dr Prof	Initials	
ID. Number			
Postal Address			
		Postal Code	
Physical Address			
		Postal Code	
Telephone (w)		Fax (w)	
Telephone (h)		Fax (h)	
Cell-phone			
Email Address			
Date of Death			
Detailed description of cause of death:			

Details of all doctors who attended to the deceased during the 5 years preceding death			
A.	Doctor		
	Hospital/clinic		
	Address		
			Postal Code
	Date attended	Ref. Number	

B.	Doctor			
	Hospital/clinic			
	Address			
			Postal Code	
	Date attended		Ref. Number	
C.	Doctor			
	Hospital/clinic			
	Address			
			Postal Code	
	Date attended		Ref. Number	

Medical aid details			
Name of Medical Aid		Medical Aid Number	
Name of Hospital		Hospital Ref. Number	
Employer Name			
Surname			
Physical Address			
		Postal Code	
Telephone (w)		Employee Number	

Section B

Particulars of the claimant							
Surname							
First Names							
Title	Miss	Mrs	Mr	Dr	Prof	Initials	
In what capacity is this claim lodged							Beneficiary Cessionary Executor
ID. Number							
Postal Address							
		Postal Code					
Physical Address							
		Postal Code					
Telephone (w)			Fax (w)				
Telephone (h)			Fax (h)				
Cell-phone							
Communication preference					Post	Fax	Email
Email Address							

Particulars of claim by cessionary			
Title		Initials	
Surname		Gender	
First Names			
Amount Claimed	R		

Signature _____

Date _____

Bank details of claimant/estate	
Bank	
Account holder	
Account no.	
Account type	
Branch code	
Branch name	

Signature _____

Date _____

Declaration and authorisation by the claimant	
Policy Schedule Number	

Declaration

I/we _____ declare that to the best of my/our knowledge all the information that I/we have given in this claim form is accurate and complete and that I/we have not withheld any information which could influence the decision on this claim. I/we further declare that I/we understand that my/our failure to disclose relevant information in respect of this claim may invalidate the claim. I/we acknowledge that I/we fully understand the contents of this declaration.

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Authorisation

I/we hereby authorise Stangen or any of its representatives to obtain any information regarding this policy from any doctor, insurer or elsewhere that may be necessary to investigate this claim. I/we further authorise Stangen or any of its representatives to release any information regarding to this claim to any other interested parties that it deems necessary in respect of this claim.

I/we warrant that I am/we are legally entitled to the proceeds under this policy and that my/our estate(s) are solvent and have not been ceded or sequestrated.

Signed on _____ day of _____ 20 ____.

Signature _____