CLAIMS
Tel: 010 020 7655
Fax: 087 942 4725
Email: claims@stangenlife.co.za

DEATH CLAIM FORM (To be completed by claimant)

Policy underwritten by: The Standard General Insurance Company Limited "Stangen", an authorised long-term insurer licenced in terms of the Long-Term Insurance Act, 1998. Registration Number 1948/029011/06 (Authorised FSP: No 47235)

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 (w)

Cell-phone

Email Address

Date of Death | Y | Y | Y | Y | M | M | D | D |

Detailed description of cause of death:

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Email: claims@stangenlife.co.za

DETAILS OF ALL DOCTORS WHO ATTENDED TO THE DECEASED DURING THE 5 YEARS PRECEDING DEATH:

C. Doctor | Address

Date attended (Y Y Y Y M M D D)

Hospital / Clinic | Ref. Number

B. Doctor | Address

Date attended (Y Y Y Y M M D D)

Hospital / Clinic | Ref. Number

A. Doctor | Address

Date attended (Y Y Y Y M M D D)

Hospital / Clinic | Ref. Number

Name of Medical Aid | Medical Aid Number

Name of Hospital | Hospital Ref. Number

Employer Name | Surname

Physical Address

Postal Code

Telephone (w) | Employee Number

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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 (w)

Cell-phone | Communication Preference: Post | Fax | Email

Email Address

PARTICULARS OF CLAIM BY CESSIONARY

Title | Initials | Gender | First Names

Surname | Amount Claimed: R

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

BANK DETAILS OF CLAIMANT / ESTATE

Name of Bank | Branch Name

Account Number | Branch Code

Name of Account Holder | Account Type

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

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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.

I / we acknowledge that I / we fully understand the contents of this declaration.

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 _____ of 20_____