www.generalunion.co.za | info@gu.co.za | 010 110 0672
267 West Avenue, Die Hoewes, Centurion, 0157

Claim form

General Union Credit Life Insurance

Details of the Insured Life/Claimant			
Policy no.			
Full name			
Surname			
ID no.		Phone no.	
Email			
Physical address			
		Code	

Details of the employer			
Company name			
Reg no.		Phone no.	
Email			
Physical address			
		Code	

Details of the Insured Life's employment			
Occupation		Employee no.	
Start date		End date	

Details of the beneficiary			
Name			
Surname			
ID no.		Phone no.	
Banking details			
Account holder			
Bank name		Branch code	
Account no.		Account type	

In case of Death Claims
- A fully completed Claim form
- Certified copy of the death certificate of the Insured
- Certified copy of the DHA 1663 form
- Police or Accident report (in case of Unnatural/Accidental Death)
- Certified copy of the Insured's ID
- Certificate of balance
- Any other documents required by the Insurer in its sole discretion.

In case of Temporary (Permanent and/or Temporary) and Critical Illness Claims
- A fully completed Claim form
- A medical report on the Disability by a Medical Practitioner
- Certified copy of the Insured Life's ID
- PDA Statement
- Certificate of Balance/s
- Any other documents required by the Insurer in its sole discretion.

In case of Retrenchment Claims
- A fully completed Claim form
- A Retrenchment letter from the employer confirming the date and reasons for Retrenchment
- A copy of the UI-19 forms
- Particulars of the Policyholder's occupation
- Policyholder's salary statement for the last date on which the Policyholder performed his/her duties, or if the Policyholder receives a commission-based salary, the Policyholder must submit the past 3 year's salary statements
- Letter from employer confirming loss of income
- Any other documents required by the Insurer in its sole discretion.

Once you've completed the form, please email your completed form and supporting documents to info@gu.co.za

Authorisation
I hereby authorise King Price Life and its duly appointed representatives to obtain any info relevant to this policy from any medical practitioner, insurer, or other relevant source, as may be necessary for the assessment and investigation of this claim. I further authorise King Price Life and its representatives to disclose any information pertaining to this claim to any third party deemed appropriate for the purpose of processing or managing this claim.

Declaration
I,_____, hereby declare that, to the best of my knowledge, all information provided in this claim form is true, accurate, and complete. I confirm that I haven't withheld any material information that could affect the assessment or outcome of this claim.

I acknowledge that any failure to disclose relevant information may result in the rejection or invalidation of this claim. I further understand that knowingly providing false, incomplete, or misleading information to an insurance company constitutes a criminal offense, which may result in penalties including fines, imprisonment, or denial of benefits. I warrant that I am legally entitled to the proceeds under this policy and hereby indemnify and hold King Price Life Insurance Limited (King Price Life) harmless against any and all claims, disputes, or liabilities from third parties arising from the payment of this funeral claim. I confirm that I have read, understood, and accept the contents of this declaration.

_____
Insured Life's/claimant's name and surname

_____ _____
Insured Life's/claimant's signature Date

Based on the type of claim, refer to the following table to see which sections need to be completed by the claimant, employer and/or medical examiner.

Type of claim	Section
Retrenchment/loss of income (employer)	A ☐
Temporary disability (employer)	B ☐
Permanent disability (employer and medical examiner)	C ☐
Critical illness (Insured Life)	D ☐

Section A: Retrenchment/Loss of income

Term of employment (select the applicable option)	
Permanent	☐
Fixed	☐
Temporary	☐
Reason for employment termination (select the applicable option)	
Retrenchment	☐
Resignation	☐
Dismissal	☐
Voluntary retrenchment	☐
Liquidation	☐
Contract expired	☐
Staff reduction program	☐
Adverse business conditions	☐
The introduction of new technology	☐
The reorganisation of the business	☐
Other, please specify	
Has the insured been offered an alternative position by the employer	Yes ☐ No ☐

Declaration
I hereby declare that the answers given on this claim form are correct, true and that no material info has been withheld or relevant circumstances omitted.

_____
Employer representative's name and surname

_____ _____
Employer representative's signature Date

Section B: Temporary disability

Date of disability	
What's the nature of the disability	
Is the insured on unpaid leave because of a medical disability	Yes ☐ No ☐
If yes, what's the unpaid leave start date	
Is the insured receiving a lesser income as a result	Yes ☐ No ☐
Date when normal working conditions will resume	

Declaration
I hereby declare that the answers given on this claim form are correct, true and that no material info has been withheld or relevant circumstances omitted.

Employer representative's name and surname

Employer representative's signature

Date

Section C: Permanent disability

Date of disability	
Cause of disability	
What's the nature of the disability	
Did the insured attend work regularly	Yes ☐ No ☐
Describe the exact nature of the insured's duties, if possible (please attach job description.)	
Was the insured employed permanently on the date of disability	Yes ☐ No ☐
If no, please provide more details	
Is the insured currently employed in any other capacity	Yes ☐ No ☐
If yes, please state in which capacity	
Is any amount payable to the insured because of the disability	Yes ☐ No ☐
If yes, please state the nature, duration and amount	
Is any remuneration payable to the insured by the employer	Yes ☐ No ☐
If yes, please state the nature, duration and amount of the remuneration	
In your opinion, is the insured able to do any other type of work/function	Yes ☐ No ☐
If yes, please provide more details	

Declaration
I hereby declare that the answers given on this claim form are correct, true and that no material info has been withheld or relevant circumstances omitted.

_____
Employer representative's name and surname

_____ _____
Employer representative's signature Date

To be completed by the medical examiner			
Full name			
Surname			
Qualification		Practice no.	
Email		Phone no.	
Physical address			
		Code	

How long have you known the insured professionally	
When were you first consulted regarding to the insured's present medical condition	
Date on which the condition arose	
Provide full details concerning the cause of the condition	
Provide a full description of the insured's present physical and mental state	
Has the excessive use of alcohol or drugs contributed to the present condition	Yes ☐ No ☐
Have you previously treated the insured for any other physical or mental conditions relating to the present illness	Yes ☐ No ☐

If yes, please complete the following

Nature of treatment	Date condition started	Date of treatment

What treatment is the insured receiving at present

Hospital/clinic name	Type of treatment	Date of treatment

Are any further treatment or operations being considered	Yes ☐ No ☐
If yes, please provide full details	

What part of the insured's normal occupational duties are they capable to carry out	
Is the insured able to follow another occupation	Yes ☐ No ☐
If yes, please provide examples of such occupation	

Declaration
I hereby declare that the answers given by me on this claim form are correct, true and that no material info has been withheld or relevant circumstances omitted.

Medical examiner's name and surname

Medical examiner's signature

Date

Medical examiner's stamp

Section D: Critical illness

Based on the policy conditions and critical illness definitions, for which condition are you claiming			
Have you submitted a critical illness claim before			Yes ☐ No ☐
If yes, please provide the details and date of claim			
On what date did the symptoms of the critical illness (that you're claiming for) start			
On what date did you first consult a medical practitioner in connection with your current condition			
On what date was your critical illness first diagnosed			
Provide the following info of the hospitals and clinics consulted in connection with your condition			
Hospital/clinic name	**Address**	**Treatment date**	**Ref no.**
Details of the doctor who's currently treating your condition			
Full name			
Surname			
Practice no.		Phone no.	
Email			
Physical address			
		Code	

Declaration
I hereby declare that the answers given on this claim form are correct, true and that no material info has been withheld or relevant circumstances omitted.

Insured Life's/Claimant's name and surname

Insured Life's/Claimant's signature

Date