

Funeral cover claim



Contact us

Tel: 0860 103 905. PO Box 3017, Rivonia 2128. www.discovery.co.za

Please attach certified copies of the following documents:

- The death certificate
- The notification of death or stillbirth (DHA-1663) (obtainable from doctor or funeral undertaker or official)
- Copy of identity document of both the deceased and beneficiary or owner if relevant
- Proof of claimant's relationship to the deceased if the deceased is not the principal life assured (e.g. marriage certificate, sworn affidavit, unabridged birth certificate if applicable)
- In the event of unnatural death:
 - o A statement by police must be completed
 - o Road traffic accident report (if applicable)
- Proof of banking details of beneficiary or owner (cancelled cheque or bank statement not older than three months)

Discovery Life reserves the right to request any additional information and documents necessary to verify the claim. Incomplete details and unclear documents may cause delays and may be requested again.

How to complete this form

- Please use one letter per block, complete with black ink and print clearly.
- To avoid administration delays, please ensure this document is completed in full.

1. Policy owner details

[illegible]

2. Details of life assured

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|----------------------|---|--|--|--|--|--|--|--|-----------|-------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------|-------------|--|--|--|
| Surname of deceased | <div></div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First names | <div></div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Previous/maiden name | <div></div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Preferred name | <div></div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Policy number | <div></div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of birth | <div><div>Y</div><div>Y</div><div>Y</div><div>Y</div><div>M</div><div>M</div><div>D</div><div>D</div></div> | | | | | | | | ID number | <div></div> | | | | | | | | | | | | | | | | | | | |
| Residential address | <div></div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <div></div> | | | | | | | | | | | | | | | | | | | | | | | | Code | <div></div> | | | |
| Postal address | <div></div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <div></div> | | | | | | | | | | | | | | | | | | | | | | | | Code | <div></div> | | | |
| Date of death | <div><div>Y</div><div>Y</div><div>Y</div><div>Y</div><div>M</div><div>M</div><div>D</div><div>D</div></div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Place of death | <div></div> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

2. Details of life assured (*continued*)

In the event of an unnatural death, please enter the police station where the death was reported:

Please provide full details of the cause of death:

In the event of a stillbirth, confirm the weeks of pregnancy at time of death:

3. Last employer details of the life assured (if relevant)

Name of employer

Surname of contact person

Full first name(s) of contact person

Address

Code

Telephone

Email address

4. Details of funeral official or undertaker

Name of funeral official
or undertaker

Surname of contact person

Full first name(s) of contact person

Address of funeral parlour

Code

Contact details of funeral parlour

Date of funeral or cremation

Place of funeral or cremation

5. Details of doctor who certified the death

Name of doctor

Contact details

Date when death was certified

Place death was certified

6. Memorial benefit

If you have selected the Memorial Benefit cover, please indicate if you would like this benefit to be paid immediately or a year later?

Immediately ☐

Later ☐

7. Details of payment

- To ensure fast payment and for your protection, payment will only be made by electronic fund transfer
- Payment will only be made to the policy owner or nominated beneficiary
- No payment to a third party will be allowed
- We will require proof of the account (cancelled cheque or bank statement with account number and name of account holder shown)

| | |
|------------------------|---|
| Name of account holder | <input type="text"/> |
| Name of bank | <input type="text"/> |
| Branch | <input type="text"/> |
| Branch code | <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> |
| Account type | <input type="text"/> |
| Account number | <input type="text"/> |

Please ensure that the above account information is correct. Discovery Life will not be held responsible for delays or other damage caused by incorrect details.

8. Claim declaration

I, _____ hereby claim the benefits of the above assurance contract(s) and declare the following:

The answers and statements I have made are true to the best of my knowledge and I have withheld no information from Discovery Life.

I agree that the written statements and affidavits submitted in support of this claim will form part of this claim.

I agree that submission of this claim to Discovery Life will be of no consequence if Discovery Life does not hold a valid assurance contract on the life assured.

I agree that benefits for this claim may require further investigation, if I or any person acting on my behalf with my consent have withheld any information or submitted any false information for this claim.

I acknowledge that payment by Discovery Life, for this benefit, will release Discovery Life from all responsibility of this claim.

I hereby consent to the exchange of information, including medical information, between Discovery Life, any medical practitioner consulted or any other life office, Discovery Health and Discovery Health Medical Scheme or any other party or any other party and authorise that Discovery Life or its representatives be furnished with such information for consideration of the claim.

Discovery Life has the right to start legal proceedings against me or any other party if any documents submitted in support of this claim are found to be false, dishonest or fraudulent. This may be done at any time including before or after payment of a benefit.

Signed at (town or city) on Y Y Y M M D

Signature of claimant

Signature of policy owner
(if different from claimant)

9. Once complete, please send this form to Discovery Life

By fax: 011 539-2508

By mail: Discovery Life
PO Box 3017
Rivonia
2128

or

By email: claims@phakama.co.za

For claims related queries call: 0123488310

or

email: claims@phakama.co.za

Any complaints should be directed to: life_complaints@discovery.co.za