• 5-IN-1 FUNERAL DEATH CLAIM FORM •

Real People Assurance Company Limited is a registered Financial Services Provider (FSP 26634)
Reg. No. 2001/028918/06 | Real People Views | 12 Esplanade Road | Quigney | East London | 5201
P.O. Box 19610 | Tecoma | 5214
HELPDESK 086 111 4803 | FAX TO 086 623 4080 | E-MAIL realinsuranceclaims@realpeople.co.za

for REAL PEOPLE®

A. HOW TO COMPLETE THE APPLICATION FORM

1. Please complete the form in black ink and in block letters;
2. This form must be completed by the main life assured or nominated beneficiary (in case of main life assured's death);
3. Submit all forms to Real People Assurance Company Limited ("RP Assurance") at the above fax number, or e-mail to assess the claim together with the following supporting documents.

CHECKLIST FOR SUBMISSION

3.1 An original certified copy of the identify document of the life assured (deceased); ☐

3.2 Proof of banking details, for example a bank statement with original bank stamp; ☐

3.3 DHA/B1 1663 (Notification of Death); ☐

3.4 An original certified copy of the death certificate; ☐

3.5 An original certified copy of identity document of the claimant; ☐

3.6 **IF DEATH WAS AS A RESULT OF UNNATURAL CAUSES**, please submit police statement completed by the investigating officer; ☐

4. Please also post originals to above address (for attention: CLAIMS). Note that claims will only be paid once original documents have been received. Please ensure that you fax or e-mail the above listed documents prior to posting them, in order to facilitate a faster claims process.

RP Assurance will contact you once we have assessed the claim. Depending on the circumstances, there may be other requirements over and above those listed in this document. Please ensure that you complete this form in full and meet all the requirements set out in this form to prevent delay of claim payment.

B. DETAILS OF LIFE ASSURED (THE DECEASED)

Policy Number

Names | Surname

Maiden Name (If applicable) | Marital Status: Single: ☐ Married ☐ Divorced: ☐ Widowed: ☐

Date of Birth D D M M Y Y Y Y | ID number

Physical Address

Area Code

Postal Address

Postal Code

Occupation

Name of Employer

Contact Person at Work

Spouse's Names | Spouse's Surname

Spouse's Maiden Name (If applicable) | Spouse's Date of Birth: D D M M Y Y Y Y

Spouse's Home No. | Spouse's Work No.

Spouse's Cell No. | Spouse's Fax No.

C. DETAILS OF CLAIMANT (MAIN LIFE OR BENEFICIARY)

Names | Surname

Relationship to Deceased | Marital Status: Single: ☐ Married ☐ Divorced: ☐ Widowed: ☐

Date of Birth D D M M Y Y Y Y | ID number

Postal Address

Postal Code

Physical Address

Postal Code

Home No. | Work No.

Cell No. | Fax No.

E-mail address

Occupation

Name of Employer

Contact Person at Work

PLEASE NOTE: That in the event of any modification or variation of this standard form, Real People Assurance Company Limited will regard this form as being invalid and of no force & effect.

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D. DETAILS REGARDING THE DECEASED

Name of Other Assurers (Assurance Held With Other Companies)	Sum Assured	Date of Issue of Assurance

Date of death D D M M Y Y Y Y

Place of death (where e.g. home, hospital etc. and please provide address details)

If place of death was hospital, please supply the following: File number, admission number and/or patient number

What was the cause of death?

Is suicide suspected? Y N

When did the health of the deceased first begin to be affected?

Name and address of every attending doctor, physician, surgeon and/or any other person associated with any medical industry, including traditional healers who may have attended the deceased during his illness over the past five years:

Doctor's Name	Telephone Number	Reason For Consultation	Date of Consultation

Name of Funeral Undertaker

Name of Contact person

Physical Address

Telephone Number Fax Number

E-mail Address

Name of deceased's school or college at date of death (if deceased was a child or dependant)

Telephone number of school or college

Did the deceased have a medical aid? Y N

Name of Medical Aid

Membership Number

Telephone Number

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E. PAYMENT DETAILS

For your protection, payment will only be made by means of an Electronic Fund Transfer (EFT), which will also ensure a more prompt payment. This payment may only be made to the owner / nominated beneficiary. WE WILL REQUIRE PROOF OF ACCOUNT, e.g. CANCELLED CHEQUE OR BANK STATEMENT THAT REFLECTS THE ACCOUNT NUMBER AND NAME OF THE ACCOUNT HOLDER. PHOTOSTAT COPIES OR FAXED COPIES ARE NOT ACCEPTABLE.

Bank Name

Branch Name Branch Code Account Type: Savings ☐ Cheque ☐ Transmission ☐

Account Number

Account Holders Name

It is very important that you provide us with the correct account number and information of the account to be credited. RP Assurance will not be held responsible for delays and/or damages incurred due to incorrect provision of information.

F. DECLARATION

I hereby warrant 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 RP Assurance.

I agree that the written statement, and affadavits of all documents 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 RP Assurance shall not constitute an admission by it that there is any assurance in force on the life in question or a waiver of any of its rights or defence 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 of the benefits hereby claimed, RP Assurance shall be discharged from all liability in respect of such benefit.

I hereby authorise Real People Assurance Company Limited and/or its holding company or any of their affiliates or subsidiaries to request information with any registered credit bureau or other entity holding information as may be reasonably required to assess the validity of the claim instituted by me.

If any false statements are made, or if any inaccruate or false Information is given by you in in your forms or anciliary documentation, which may lead to your claim being approved, or any fraudulent declaration is made by you, your cover will be void and no benefits under the policy will be payable and all premiums paid will be forfeited.

In the event that a claimant is incapable of managing his/her own affairs, an appointment of a curator bonis will be required in order for RP Assurance to further assess the claim.

Signed at (place) On (date) D D M M Y Y Y Y

SIGN HERE

Claimant's Signature

Claimant's Name (Please Print)

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