Sanlam Life Insurance

9th Floor Amani Place, Ohio Street, PO Box 22229 Dar es Salaam Tanzania
Tel: +255 22 212 7151/2/3, Fax: +255 22 212 7154

GROUP LIFE ASSURANCE CLAIM FORM

1. Insured: _____

2. Full Name of Employee: _____

   Staff Number: _____

3. Nature of loss: a) Death ☐ b) Critical Illness ☐ c) Disability ☐

4. Date of Illness/Disability /Death: _____/_____/_____ (DD/MM/YYYY)

5. Circumstances surrounding the incident:

   _____

6. Please attach the following documents where applicable:

Death:	*(tick)*
Original Burial Permit / Death Certificate	
Copy of Deceased Identity Card	
Copy of last pay slip	
Critical Illness:	
Medical Prognosis	
Accident Disability:	
Medical Certificate	

7. Attending Doctor:

   Name: _____

   Address: _____

   Telephone: _____

I hereby acknowledge that the information provided above is correct and that the company may call for further information it may require.

Signature and stamp of policy holder: _____ Date: _____