

Sanlam Easy Retirement Plan

Funeral claim form

Please indicate type of claim:

Death of member		Please complete Sections A, B, E & G
Death of spouse		Please complete Sections A, C, E, F & G
Death of child		Please complete Sections A, D, E, F & G

Submitting of funeral claim forms

This funeral claim form must immediately be forwarded directly to the Risk Insurer (and not to the administrator's office) to ensure that the Risk Insurer meets the turnaround time of 48 hours to pay out funeral claims.

Please e-mail the completed documentation to: GBGAPClaims@sanlamsky.co.za

SECTION A: Particulars of the member (*The Insured*)

Title and Initials:		Date of Birth:	
Full Names and Surname:			
Member Number:		ID Nr / Passport Nr:	
Participating Employer:		Fund Code:	
Mobile Number:		Alternative Number:	
E-mail address:			

SECTION B: Particulars of the deceased member (*To be completed by the employer in case of death of the member*)

Title and Initials:		Date of Birth:			
Full Names and Surname:					
Member Number:		ID Nr / Passport Nr:			
Participating Employer:		Fund Code:			
Gender:		Marital Status:			
Home Address:		Postal Address:			
Date of last contribution:		Last date of active service:		Date of death:	
Exact cause of death:					

Please provide certified copies of the documents below applicable to the deceased member:

- | | |
|--------------------------|---|
| <input type="checkbox"/> | In case of an unnatural death, a certified copy of the police / traffic report & post-mortem report |
| <input type="checkbox"/> | Official computerised death certificate as issued by the Department of Home Affairs |
| <input type="checkbox"/> | Identity document of the deceased member and beneficiary |
| <input type="checkbox"/> | The Notice of Death form (83/BI-1663 - all pages) as issued by the hospital/doctor |
| <input type="checkbox"/> | All payments are to be made into a bank account. We require a bank certified copy of the beneficiary's bank statement or cancelled cheque |
| <input type="checkbox"/> | The members signed beneficiary nomination form |

SECTION C: Details of the deceased spouse

Full names and surname:			
ID Nr / Passport Nr:		Gender:	
Exact cause of death:		Date of death:	

Please provide certified copies of the documents below applicable to the deceased spouse:

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Official computerised death certificate as issued by the Department of Home Affairs |
| <input type="checkbox"/> | Identity document of both the member and the deceased spouse |
| <input type="checkbox"/> | The Notice of Death form (83/BI-1663 - all pages) as issued by the hospital/doctor |
| <input type="checkbox"/> | Marriage Certificate or in the case of a marriage recognised as a customary marriage, a certificate of registration or an affidavit in respect of a customary marriage from a community leader or priest |
| <input type="checkbox"/> | All payments are to be made into a bank account. We require a bank certified copy of the beneficiary's bank statement or cancelled cheque |

SECTION D: Details of the deceased child

Full names and surname:			
ID Nr / Passport Nr:		Gender:	
Exact cause of death:		Date of death:	

Please provide certified copies of the documents below applicable to the deceased child:

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Official computerised death certificate as issued by the Department of Home Affairs |
| <input type="checkbox"/> | Identity document or Birth Certificate as well as Identity Document of the member |
| <input type="checkbox"/> | The Notice of Death form/Still Birth (83/BI-1663 - all pages) as issued by the hospital/doctor |
| <input type="checkbox"/> | In the event of Still Birth the claim will only be accepted from 26 weeks and over. We therefore require a letter from the doctor/hospital confirming at how many weeks the child was born |
| <input type="checkbox"/> | A sworn affidavit stating that the deceased child was the insured's or his/her spouse's child if the surnames of the insured and the qualifying child differ |
| <input type="checkbox"/> | All payments are to be made into a bank account. We require a bank certified copy of the beneficiary's bank statement or cancelled cheque |

SECTION E: Payment Details

1. Banking details of beneficiary:

Name of account holder:		Name of bank:	
Account number:		Branch code:	
Account type:	Savings	Cheque	Current

Please note the following:

- All payments are to be made into a bank account
- Payments cannot be made to credit card or bond accounts
- Payments cannot be made to a third party
- Payments cannot be split into different bank accounts

SECTION F: Declaration by the member in the instance of death of a spouse or child

I, the undersigned member, hereby confirm that the information given herein is true and correct.

Member's Signature _____

Date _____

Disclaimer

Personal Information (PI) requested in this form is mandatory for operational and administrative processes, and to comply with regulatory requirements. If the mandatory information is incomplete, your request may not be processed. Sanlam Life Insurance Limited will take reasonable steps to ensure that the PI collected on this form is processed responsibly, kept safe and confidential, and does not unjustifiably infringe your privacy. You can read the Sanlam Privacy Notice on <https://www.sanlam.com/legal/pages/sanlams-privacy-policy.aspx>; it can be sent to you on request. You can update your contact details by registering and logging onto our member portal here: <https://cp.sanlam.co.za> or email: SCClientCare@sanlam.co.za or call: 086 122 3646.

SECTION G: Declaration by the employer in all instances

I, the undersigned authorised signatory of the employer, hereby certify that:

- All particulars furnished in this form and accompanying documentation are true and correct
- The signature above is that of the aforementioned member and I have verified all the information provided

Signed on behalf of Employer (Only the Authorised Signatory can sign off the claim form) _____

Full Name: _____

Designation: _____

Date: _____

EMPLOYER'S STAMP