



3. Particulars of Hospital/Doctor:

Place of Death: _____

Hospital Name: _____

Address: _____

Telephone No.: _____

Name and Address of the Doctor who confirmed death: _____

In/Out Patient No.: _____

Telephone No. of Doctor: _____

Name and Telephone No. of all Hospitals/ Doctors who attended the deceased 2(two) years prior to death:

Nature of Illness _____ Nature of Treatment: _____

Year/Month of Treatment: _____ / _____ / _____ (DDMMYY)

Test Done and Results: _____

Date of Death: ____ / ____ / ____ (DD/MM/YYYY)

Address of deceased: _____

4. Particulars of the Claimant:

Last Name : _____ Nature of Treatment: _____

First Name : _____

Date of Birth: ____ / ____ / ____ (DDMMYY)

ID Document Provided : _____

Home Address : _____

Mobile Number : _____

Occupation : _____ Employer/School : _____

Work Address : _____

Land Line Telephone No. : _____



5. Payment Details :

How would you like to receive the cheque(s)? To be collected Via the Post Bank Account

The following information must be completed in ALL circumstances:

Account Name: _____

Name of the Bank: _____

Branch Name: _____

Account Number: _____

Claimant's Signature: _____

Date: _____ / _____ / _____ (DD/MM/YYYY)

6. Declaration :

I/We further declare that the above statements and answers to the above questions are true and full, that I/we have withheld no material information and that I/we undertake to furnish any documentation, which may be required by Sanlam Life Insurance Limited. I expressly waive all provisions of law, custom or professional etiquette forbidding any physician or other person who attended or examined the deceased, or any institution in which the deceased received treatment, to disclose any knowledge or information which was thereby acquired and I authorize all such persons or agencies to furnish any information in their possession to Sanlam Life Insurance (Tanzania) Limited.

1 . _____ Date: Date: _____ | _____ | _____ (DD/MM/YYYY)

2 . _____ Date: Date: _____ | _____ | _____ (DD/MM/YYYY)

Signature(s) of claimant(s)

WITNESS (Must be Head of Dept, Head Teacher, or a Religious Leader)

Name: _____

Landline No.: _____

Signature: _____ Date: Date: _____ | _____ | _____ (DD/MM/YYYY)

Address and Stamp: _____

7. Official Use (Do not write here) :

Death Certificate Salary Advice Birth Certificate Burial Permit Affidavit Deceased ID

Claimant ID Other: _____

Completed by: _____ Date: Date: _____ | _____ | _____ (DD/MM/YYYY)

I have prepared and checked this claim _____ (Signature) Date: Date: _____ | _____ | _____ (DD/MM/YYYY)

I have verified and approved this claim _____ (Signature) Date: Date: _____ | _____ | _____ (DD/MM/YYYY)