Application for Payment of a Death Claim: Life

Requirements for MiWayLife to process the Claim

- EVERY QUESTION MUST BE COMPLETED IN FULL.
- Original / Certified copy of the printed (Home Affairs) death certificate (BI5) must be supplied (no abridged Death Certificate's will be accepted).
- Certified copy of ID Book of deceased and claimant, certified by a Commissioner of Oaths.
- Proof of Bank Account details of claimant (i.e. cancelled cheque or bank account statement), or estate account details in the event of no nominated beneficiaries).
- Copy of the DHA 1663 – Notification of Death (obtainable from the doctor who certified the death or the undertaker)
- Funeral Parlour Invoice including telephone number, physical address and stamp.
- Fully completed police report (MiWayLife Police Report form) in the case of accidental/ unnatural death.
- Attach copy of the Road Traffic Accident Report in case of a Motor Vehicle Accident.

Submitting the claim:

The above documents plus this claim form, correctly completed and signed, must be submitted to MIWAYLIFE using one of the following methods

- Fax to MIWAYLIFEon fax number 27 11 990 0094, or
- Post MIWAYLIFE, PostNet Suite #409 Private Bag x 30500, Houghton, 2041

Definitions:

1. Policy Schedule

   The original but latest Policy Schedule sent to the insured on or after the commencement of the life cover.

2. The Life assured

   The person on whose life the life insurance cover was effected in terms of the Policy Schedule.

3. Identity Document (ID)

   An official ID document, passport or both sides of a card driving license which must include the identity number, photographs, first names and surname of the person.

4. Cessionary

   The entity to which the policy has been partially or fully transferred by way of cession, for e.g. security of a loan.

Section A: Particulars of the Insured (Deceased)

1. Policy Number _ _ _ _ _ _ _ _ _ _ _ Title _ _ _ _ _ Initials _ _ _ Gender _ _ _

First Names _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Surname _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

ID /Passport/Card Driving License Official Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Language _ _ _ _ _ _

Postal Address _ Postal Code_ _ _ _ _ _ _ _ _ _ _ _ _

_ _

Physical Address _ Postal Code_ _ _ _ _ _ _ _ _ _ _ _ _

_ _

Telephone (Work) _ _ _ _ _ _ _ _ _ _ _ _ Fax (Work) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Telephone (Home) _ _ _ _ _ _ _ _ _ _ _ _ Fax (Work) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Cell phone _ _ _ _ _ _ _ _ _ _ _ _ _ E-mail Address _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

2. Date and time of death _ _ / _ _ /_ _

3. Detailed description of cause of death _____

_____

_____

4. Details of all Doctors who attended to the deceased during the 5 years preceding death:

(a) DR. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Address _

_ Postal Code _ _ _ _ _

Telephone (Work) _ _ _ _ _ _ _ _ _ _ _ _ Date Attended _ _ / _ _ /_ _

(b) DR. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Address _

_ Postal Code _ _ _ _ _

Telephone (Work) _ _ _ _ _ _ _ _ _ _ _ _ Date Attended _ _ / _ _ /_ _

(c) DR. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Address _

_ Postal Code _ _ _ _ _

Telephone (Work) _ _ _ _ _ _ _ _ _ _ _ _ Date Attended _ _ / _ _ /_ _

5. (a) Did the deceased commit suicide? Yes ☐ No ☐ Under Investigation ☐

(b) Was the deceased death caused by his/her transgression of any law?
Yes ☐ No ☐ Under Investigation ☐

(c) Was the deceased death caused by another person's violence?

Yes ☐ No ☐ Under Investigation ☐

6. Name of Medical Aid _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Medical Aid No. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Name of Hospital. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Hospital reference no. _ _ _ _ _ _ _ _ _ _ _

7. Employer Details: Name _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Surname _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Physical Address _ Postal Code _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

_ _

Telephone (Work) _ _ _ _ _ _ _ _ _ _ _ Employee No. _

Section B: Particulars of the Claimant

Title _ _ _ _ _ Initials _ _ _ Gender _ _ _

First Names _ Surname _

In what capacity is this claim lodged (beneficiary, cessionary, executor)? _

ID /Passport/Card Driving License Official Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Language _ _ _ _ _ _ _ _ _ _

Postal Address _

_ Postal Code _ _ _ _ _

Physical Address _

_ Postal Code _ _ _ _ _

Telephone (Work) _ _ _ _ _ _ _ _ _ _ Fax (Work) _ _ _ _ _ _ _ _ _ _ _ _ _ _

Telephone (Home) _ _ _ _ _ _ _ _ _ _ Fax (Work) _ _ _ _ _ _ _ _ _ _ _ _ _ _

Cell phone _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ E-mail Address _

Communication Preference Post ☐ Fax ☐ E-mail ☐

Section C: Particulars of the Claim by Cessionary

Title _ _ _ _ _ Initials _ _ _ Gender _ _ _ _ First Names _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Surname _ Amount Claimed R _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Signature ______________________________ **Date** _ _ / _ _ /_ _

Section D: Bank Details of the Claimant/Beneficiary

Name of the Bank _ **Branch Name** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Branch Code _ **Account Claimed R** _ _ _ _ _ _ _ _ _ _ _ _ _ _

Name of Account Holder _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ **Account Type** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Signature of Account Holder _____ **Date** _ _ / _ _ /_ _

Section E: Declaration and Authorisation by the Claimant

Policy Number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Declaration

I/we declare that to the best of my/our knowledge all the information that I/we have given in this claim form is accurate and complete and that I/we have not withheld any information which could influence the decision on this claim. I/we further declare that I/we understand that my/our failure to disclose relevant information in respect of this claim may invalidate the claim. I/we acknowledge that I/we fully understand the contents of this declaration.

Authorization

I/we hereby authorize MIWAYLIFE or any of its representatives to obtain any information regarding this policy from any doctor, insurer or elsewhere that may be necessary to investigate this claim. I/we further authorize MIWAYLIFE or any of it's representatives to release my information regarding this claim to any other interested parties that it deems necessary in respect of this claim. I/we warrant that I am/we are legally entitled to the proceeds under this policy and that my/our estate(s) are solvent and have not been ceded or sequestrated.

Signed at _____

Signature of Claimant(s) _____ Date _ _ _/_ _ _/_ _ _

Signature of Commissioner of Oath/Justice of the peace _____

Official Stamp Date _ _ _/_ _ _/_ _ _

Section F: To be completed by MiWayLife

Policy number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Commence date of Policy _ _ _/_ _ _/_ _ _

Date Claim received by MIWAYLIFE _ _ _/_ _ _/_ _ _

Details of Claims Committee Decision _____

_____

Name _ **Position** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Signature _____