OLD MUTUAL Death/Disability Benefit Request - Group Schemes

Branch | **Branch Tracking/Workflow No** | **Date & Time**

Personal and Address Information (Policyholder)

Name:
Identity Number:
Directory Id:
Gender:

Address:

Contact Details:
Home: Cell:
Work: Fax:
Email address:

Claimant/Beneficiary Details

Policy Number _____

Prefix _____ Initials _____ First Name _____ Surname _____

Date of Birth _____ Identity Number _____ Policy Number _____

Postal Address : _____ (_____)_____ Telephone (H)

_____ (_____)_____ Telephone (W)

_____ _____ Telephone (C)

_____ _____ Postal Code

Details of Deceased/Disabled

Relationship to policyholder : _____

Prefix _____ Initials _____ First Name _____ Surname _____

Identity Number _____ Date of Birth _____ Date of Death _____

Cause of Death/Disability:
☐ Accidental
☐ Non-Accidental

Cause of Death/Disability

☐ Tuberculosis (TB) (22) ☐ Flu/Pneumonia/Respiratory (6) ☐ Intestinal/Stomach (8) ☐ HIV/AIDS (92),
☐ Cancer/Tumour (4) ☐ Heart-related (5D) ☐ Diabetes (7K) ☐ Brain-related (3)
☐ Other (53) _____

Payment Instruction (of Beneficiary if available)

☐ Electronic Transfer ☐ Cheque Collection ☐ Posting

Payee _____ Account Holder/Payee _____

Addressee _____ Branch Code _____

Address _____ Account Number _____

Account Type _____

I, the undersigned, declare that all the information provided in this document is complete and accurate. I agree that the reasons for approving/declining this Benefit Request has been explained to me.
I, the undersigned, hereby request Old Mutual to post the cheque to the address given or deposit the proceeds into the banking account provided.
I hereby absolve Old Mutual from any risk or liability resulting in the cheque being lost in the post or the proceeds deposited into the incorrect bank account.

Claimant Signature _____ Date _____

OLD MUTUAL

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Confirmation of Death/Disability (please complete/tick where applicable)

Place of Death/Disability _____

☐ Employer of Deceased/Disabled ☐ Hospital ☐ Medical Practioner ☐ Funeral Parlour

☐ Police Station ☐ School ☐ Tribal Chief

_____ Place	_____ Place
_____ Contact Person	_____ Contact Person
_____ Capacity	_____ Capacity
(_____) _____ Telephone Number	(_____) _____ Telephone Number
_____ Date of funeral	

BODY TRANSPORTATION
(Applicable to Funeral policies only)

Body transportation from place of death to the funeral home closest to place of burial.

If you would you like to make use of this benefit, call :

- **South Africa 0860 00 19 19**
- **Namibia 061 221 307**
- **Swaziland 07 21 5031791**

who will assist you with the arrangements.

Office Use Only

Staff Initials and Surname _____ Staff Code _____

Staff Signature _____ Date _____

Commissioner of Oaths/Old Mutual Representative (Complete for Thumbprint)

The thumbprint below and the marks made in this document are that of the client/claimant specified in the document and have been placed in my presence.

Capacity	Signed at	On this date	Signature

THUMBPRINT

☐ Right Thumb

☐ Left Thumb

OFFICIAL STAMP