

AMANI FAMILY FUNERAL PLAN – CLAIM FORM

<p>1. Basic Requirement:</p> <p>Certified Copy of the Burial Permit: _____</p> <p>Certified Copy of ID (Claimant): _____</p> <p>Certified Copy of Proof of Age (Deceased): _____</p>	<p>Policy Document: _____</p> <p>Policy Report (If unnatural Death): _____</p> <p>Ward Executive officer's Name (Mtaa): _____</p> <p>Ward Executive officer's Telephone No.(Mtaa): _____</p>
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Note: Sanlam Life Insurance (Tanzania) Limited reserves the right to request any additional documentation it deems necessary to verify claim.

Policy Number:	Life Assured: _____										
<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>											
Benefit Type: Life Assured <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Wider <input type="checkbox"/>											

2. Particulars of the Deceased:

Last Name : _____	MALE	FEMALE	
First Name: _____			
Date of Birth: _____ / _____ / _____ (DD/MM/YY)			
Date of Death: _____ / _____ / _____ (DD/MM/YY)			
Address of Deceased: _____			
Occupation: _____ Employer: _____			
Work Address: _____			
Telephone Number: _____			
Exact cause of Death: _____			
List any other policies the deceased may have been covered under:			
⊙ Policy No.: _____	Company: _____		
⊙ Policy No.: _____	Company: _____		



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 :	_____	MALE	FEMALE
First Name:	_____	<input type="checkbox"/>	<input type="checkbox"/>
Date of Birth:	_____/_____/_____		
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: _____ | _____ | _____ (DD/MM/YYYY)

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

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

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