Allianz

DEATH CLAIM FORM

POLICY NUMBER:

SELECT TYPE OF POLICY: FAREWELL PLAN ☐ WEALTH PLANNER ☐ TERM LIFE PLAN ☐

1. PARTICULARS OF DECEASED

First Name: Surname:

Maiden Names Where Applicable: Relationship to Claimant:

Date Of Birth:

a. Contact Details (Telephone numbers)

Mobile: Work:

House No: Postal address:

Town: Notable Landmark:

b. Employer Details (Deceased)

Organisation: Occupation:

Address: Telephone:

Location (Notable landmark)

c. Religious Details

Religion: Contact Number:

d. Death Description

Date Of Death: Time Of Death:

Place Of Death: Home ☐ Hospital ☐ Other:

CAUSE OF DEATH: Natural ☐ Accidental ☐ Exact Cause of Death

e. Details of Mortuary /Funeral Home

Where Is Body Deposited? : Mortuary ☐ Funeral Home ☐

Name of Mortuary/ Funeral Home: Phone Number:

f. Death by Accident (If applicable) *Please Attach a Copy of Police Findings where applicable*

Place Of Accident: **Brief Description Of Accident:**

Name And Address Of Police Station:

g. Medical Details:

Hospital Name: Name of Doctor:

Phone Number (Doctor and Hospital):

h. Burial Information

Has Deceased Been Buried? : Yes ☐ No ☐ Date of Burial/Intended Date for Burial:

Name of Cemetery/Intended Cemetery:

Name Of Religious Body That Handled The Burial Service:

2. PARTICULARS OF CLAIMANT

First Name: Surname: Date Of Birth:

a. Contact Details

Mobile: Work:

Postal Address: Email Address

b. Physical Address

Town: House Number:

Notable Landmark:

c. Employer Details (Name, Location, Contact Number)

Name Location Tel Number

d. Payment Option: Electronic Funds Transfer (Eft): ☐ **Cheque:** ☐

Bank Details

Name of Bank:

Account Name:

Domiciled Branch:

Account Number:

I declare that the above statement and answers to the preceding questions are true and I have not withheld relevant material. I undertake to give any records which may be required by Allianz Life and clearly relinquish all provisions of law ,customer professional etiquette forbidden by a physician or other persons who attended to the deceased, or any institution the deceased received treatment, to disclose any knowledge or information which is by this means required by Allianz Life.
I authorize all such persons and organizations to furnish any information in their possession to Allianz Life.

SIGNATURE OF CLAIMANT: …… SIGNED DATE: ……..

OFFICE USE ONLY

CHECK LIST

- Signed Claim form ☐
- Policy Document ☐

In case of accidental disability/death;

- *Police Report* ☐

Evidence of Death

- *Medical Certificate of Cause of death* ☐
- *Death Certificate* ☐
- *Burial permit* ☐

Proof of identity

- *Voters ID* ☐
- *Passport* ☐
- *Drivers Licence* ☐

CLAIMS RELATIONSHIP OFFICER

Name:

Branch:

Signature:

Date dispatched: