



DEATH BENEFIT CLAIM FORM

6

ABOUT THE DECEASED'S EMPLOYER

For reference purposes:

Name and Surname of the Deceased (as per the ID book)	
ID Number or Passport Number of the Deceased	

This Claim Form 6 provides us with information about the **Deceased's Employer**. It should be completed by the Deceased's Employer – for example, an HR staff member or manager.

If you need help filling in this form, please call 021 509 4351.

Please return these forms to: OLD MUTUAL GROUP ASSURANCE
PO Box 1659
Cape Town 8000

Email: GAPdeathclaims@oldmutual.com
Fax: 021 509 4669

A

DETAILS OF THE DECEASED'S EMPLOYER

Name of employer	
Contact person (name and surname)	
Email address	
Postal address	
Cellphone	
Telephone (W)	
Fax number	

B

DEDUCTIONS FROM THE BENEFIT

Is there any amount of money which should be deducted from the Death Benefit to cover damage caused by the Employee as a result of theft, dishonesty, fraud or wrongdoing by the Deceased, where the Deceased has agreed this in writing with the Employer or where the Deceased has been found guilty in any court of law?

Court case number		Written admission	Y/N
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Please attach a **CERTIFIED COPY** of court judgement or Written Admission

Are you aware of the member having any of the following?

Divorce Orders which need to be deducted from the Fund?	Y/N	Housing Loan Surety from the Fund?	Y/N
Was the death due to unnatural causes (e.g. accident, murder, or suicide)?			Y/N

C

DETAILS ABOUT DEPENDANTS

Please provide us with brief details about any children of the Deceased (biological, adopted, foster or step-children) that you are aware of. Please ask colleagues or friends of the Deceased for information, to make sure you find out as much information as possible.

Children of the deceased				
Child's full name	Child's date of birth	Did the Deceased support the child financially?	Name of biological mother of the child	Name of biological father of the child
		Y/N		
		Y/N		
		Y/N		
		Y/N		

Please list anyone else who may have depended financially on the Deceased at the date of death. Please ask colleagues or friends of the Deceased for information.

Any other Dependents (e.g. husband or wife, partner, parent, brother or sister, or similar)		
Full name	Date of birth	Relationship to the deceased

D

DECLARATION BY EMPLOYER

Please provide us with brief details about any children of the Deceased (biological, adopted, foster or step-children) that you are aware of. Please ask colleagues or friends of the Deceased for information, to make sure you find out as much information as possible.

I, _____ (full names and surname) declare that

- all details provided in this document and the supporting documentation are true and correct; and
- the options in terms of the Rules of the Fund have been fully explained to the beneficiaries.

I hereby acknowledge and take note that providing false information on this form is a criminal offense and that criminal charges can be laid against me.

Signed at		Date	
Telephone		Job title	
Signature		Official stamp	

E

STATEMENT BY A COMMISSIONER OF OATHS

The person mentioned above has signed this Form in front of me. They have stated that they know and understand the contents of this affidavit. They have confirmed that they have no objections to this oath, and that the oath is binding on their conscience.

Commissioner of Oaths: Full Name & Surname			
Telephone		Designation	
Signature of Commissioner of Oaths		Official stamp	



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