Death Claim Form

Hollard.

(To be completed by usual medical attendant)

Please note that it is essential to complete this form in full to prevent unnecessary delays as a result of missing information.

Please note that should there be any charges for the completion of this form, such charges will be for the claimant's account.
Return the completed form and the above documents to lifeclaims@hollard.co.za **or fax to 086 659 0135.**

1. Life assured details

Policy no. _____ ID no. _____

Name of insured _____

Date of birth D D M M Y Y Y Y Date of death D D M M Y Y Y Y

Place of death _____ Duration of illness if natural causes _____

Provide full details of the cause of death ('natural causes' or 'unnatural death' is not sufficient – state the circumstances leading to death)

_____

1.1. a. Are you the usual medical attendant of the deceased? ☐ Yes ☐ No

If yes, how long have you known him/her? _____

If no, supply the name, address and telephone number of the usual medical attendant

_____

_____

_____

1.2. Was the death as a result of illness? ☐ Yes ☐ No

If yes:

a. Date when the deceased first became aware of it or any symptoms D D M M Y Y Y Y

b. Date when the illness was diagnosed D D M M Y Y Y Y

State any disease or conditions which preceded or co-existed with the immediate cause of death and the date of diagnosis

Condition _____ D D M M Y Y Y Y

Condition _____ D D M M Y Y Y Y

Condition _____ D D M M Y Y Y Y

Condition _____ D D M M Y Y Y Y

Indicate any other complaints for which the deceased consulted you and date of diagnosis

Condition _____ D D M M Y Y Y Y

Condition _____ D D M M Y Y Y Y

Condition _____ D D M M Y Y Y Y

Condition _____ D D M M Y Y Y Y

1.3. Was the death as a result of an accident? ☐ Yes ☐ No

If yes:

a. When did you first attend to the deceased with regard to the injuries sustained in the accident? D D M M Y Y Y Y

b. Give full details of the nature of the injuries sustained by the deceased

_____

_____

_____

1.4. a. Has the deceased ever been tested for HIV antibodies? ☐ Yes ☐ No

If yes, what was the result of the test and when was it done?

D	D	M	M	Y	Y	Y	Y

1.5. Indicate the names and addresses of any other doctor(s) consulted by the deceased during the past 5 years, other than these mentioned above

1.6. Did the deceased use tobacco in any form? ☐ Yes ☐ No

1.7. Was an inquest or post mortem inquiry held? ☐ Yes ☐ No

1.8. Provide any other relevant facts relating to the deceased's medical history or habits

2. Declaration by medical attendant

I declare that I have personally attended to the patient and that this form has been completed to the best of my knowledge.

Full name

Qualifications Practice no.

Work tel. no. Cell no.

E-mail address

Postal address

Signature **Date**

D	D	M	M	Y	Y	Y	Y