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Reg. No. 1973/008933/06

## ACE Insurance Limited

### ACE Insurance Limited Claim Form – Death Claim

- PLEASE USE BLACK INK AND BLOCK CAPITALS
- PLEASE RETURN THE COMPLETED CLAIM FORM TOGETHER WITH ANY ENCLOSURES TO YOUR INSURANCE BROKER OR TO ACE AT THE ADDRESS SHOWN.
- THE COMPLETION AND/OR SUBMISSION OF THIS CLAIM FORM TO US DOES NOT CONSTITUTE AN ADMISSION OF YOUR CLAIM BY ACE INSURANCE LIMITED SOUTH AFRICA

<b>PLEASE ENSURE (✓)</b>	
You fully complete <u>every</u> question contained in this claim form	<input type="checkbox"/>
You have enclosed all requested information/documentation. If not, please ensure that any documentation to follow the submission of this claim, has the policy number written in the top right hand corner.	<input type="checkbox"/>
<b>PLEASE ATTACH TO THIS CLAIM FORM, OR FORWARD AS SOON AS THEY ARE AVAILABLE, COPIES OF THE FOLLOWING DOCUMENTS:</b>	
<ul style="list-style-type: none"> <li>· Identity document of the deceased</li> <li>· Identity document of the policy holder</li> <li>· Death certificate of the deceased</li> <li>· Road traffic collision report (if death was due to a motor vehicle accident )</li> <li>· Post mortem report with blood alcohol test report</li> <li>· Inquest report and/or court proceeding report</li> <li>· Letter of appointment of the executor of the estate</li> <li>· Police report</li> </ul>	
You or your legal representative has signed the claim form	<input type="checkbox"/>

### 1.1. PERSONAL DETAILS

Name of Employer:		Occupation:	
Name of Policy:			
Certificate/Policy Number:			
Full Name of Insured Person:		(Mr,Mrs,Miss,Ms)	
Date of Birth:		I.D. no:	
Physical Address:			
Tel. no (Business):		Tel. no (Home):	
Fax. no:		Cellphone no:	
E-mail:			

### 1.2. DECEASED DETAILS

Full name of the deceased:		(Mr,Mrs,Miss,Ms)	
I.D. no:		Date of Birth:	
<b>(PLEASE ATTACH A CERTIFIED COPY OF THE ID)</b>			
Name of person submitting this claim:			
What is your relationship to the deceased?			
What is your relationship to the Main Policyholder?			
<b>(PLEASE ATTACH NECESSARY DOCUMENT AS PROOF)</b>			
Name of the deceased's usual Doctor, Clinic or Hospital:			
Tel. no:		Fax. no:	

### 1.3. DETAILS OF THE ACCIDENT

IF A MOTOR ACCIDENT OCCURRED, PLEASE ATTACH A COPY OF THE ROAD TRAFFIC COLLISION REPORT.

Date of accident:		Time of accident:	
The accident occurred where:			
Name of police station where accident was reported:			
Telephone no. of the Police Station:			
Please state the CAS no. as provided by the Police Station:			
Please provide the name and contact details of the Investigating Officer handling this case:			
Please describe as <u>fully as possible</u> , how the accident happened:			

### 1.4. AUTHORISATION

PLEASE NOTE THAT THIS CLAIM FORM WILL NOT BE ACCEPTED IF THIS DECLARATION HAS NOT BEEN SIGNED BY THE CLAIMANT OR AUTHORISED PERSON.

I \_\_\_\_\_ hereby declare and warrant that the information given in this claim form is in every respect complete, correct and true.

I authorise any medical practitioner, hospital or other person to provide ACE Insurance Limited with any information they may require relating to the medical history of the deceased and the injury(ies) to which the claim relates. I agree that this consent shall remain in force at all times, and that a photo-copy or fax of this declaration shall be accepted as the original. I agree and accept that ACE Insurance Limited may request additional information from any medical practitioner, hospital or any other person not specifically requested herein, on completion and submission of this form and any other documentation as submitted by me.

Signed by the claimant or his/her legal representative on this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_.

Signature: \_\_\_\_\_