



ACE Insurance Limited

DEATH BENEFIT CLAIM FORM

1. THANK YOU FOR NOTIFYING US OF YOUR CLAIM, THE ISSUE, COMPLETION AND SUBMISSION OF THIS CLAIM FORM DOES NOT CONSTRUE AN ADMISSION OF LIABILITY BY ACE INSURANCE LIMITED.
2. THE POLICYHOLDER IS RESPONSIBLE FOR THE PAYMENT OF ANY FEES IN CONNECTION WITH THE COMPLETION OF THIS FORM
3. **ONLY A FULLY COMPLETED AND SIGNED CLAIM FORM CAN RECEIVE OUR FULL ATTENTION.**
4. PLEASE COMPLETE ALL QUESTIONS – IF ANY QUESTION(S) IS NOT APPLICABLE PLEASE STATE "N/A"
5. **PLEASE USE BLACK INK AND BLOCK CAPITALS AND WRITE NEATLY AND CLEARLY.**
6. **PLEASE ATTACH TO THIS CLAIM FORM, OR FORWARD AS SOON AS THEY ARE AVAILALBLE, COPIES OF THE FOLLOWING DOCUMENTS:**
 - IDENTITY DOCUMENT OF THE DECEASED
 - IDENTITY DOCUMENT OF THE POLICY HOLDER
 - DEATH CERTIFICATE OF THE DECEASED
 - ROAD TRAFFIC COLLISION REPORT (IF DEATH WAS DUE TO A MOTOR VEHICLE ACCIDENT)
 - POST MORTEM REPORT WITH BLOOD ALCOHOL TEST REPORT
 - INQUEST REPORT AND/OR COURT PROCEEDING REPORT
 - LETTER OF APPOINTMENT OF THE EXECUTOR OF THE ESTATE
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THIS SECTION IS TO BE COMPLETED BY THE POLICY HOLDER OR AUTHORISED PERSON

Scheme Name: Med-Care 24 Plus	Policy Number:
Application / Certificate Number:	Effective Date of first joining the Scheme:
Name of the main Policy Holder on the application form:	
Full name of the deceased: (Mr, Mrs, Miss, Ms)	
Date of Birth:	I.D. no: (PLEASE ATTACH A CERTIFIED COPY OF THE ID)
What is your relationship to the Main Policyholder?	
Name of person submitting the claim:	
What is your relationship to the deceased? (PLEASE ATTACH NECESSARY DOCUMENT AS PROOF)	

What is the physical address of the policyholder?



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Postal Code:

Tel. no (Business): ()

(Home): ()

Cellphone no:

Name of the deceased's usual Doctor, Clinic or Hospital:

Tel. no: ()

Fax no: ()

Name and postal addresses of any other medical practitioners who treated the deceased for this injury:

Please note that 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



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DETAILS OF THE ACCIDENT:

 THIS SECTION IS TO BE COMPLETED BY THE POLICY HOLDER OR AUTHORISED PERSON

 ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE CLAIMANT. IF A MOTOR ACCIDENT OCCURRED, PLEASE ATTACH A COPY OF THE ROAD TRAFFIC COLLISION REPORT.

The accident occurred at: _____ (Place)
on _____ (Date)
at: _____ (Time)
me)

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 fully as possible, how the accident happened:



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DECLARATION:

👉 POLICY HOLDER – IT IS IMPORTANT THAT YOU ENSURE THAT YOU SIGN HEREUNDER.

PLEASE NOTE THAT THIS CLAIM 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 any 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 this 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 _____ 200_____

Signature: _____ Name (Please print): _____

Relation to Deceased:

Relation to Claimant:

Please list additional information and/or documentation attached to this claim (as listed on page 1 of claim form):



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Please list additional information and/or documentation not attached to this claim at the time of submission:

 **PLEASE ENSURE (✓)**

- You fully complete every question contained in this claim form
- You have enclosed all requested information/documentation. If not, please ensure that any documentation to follow the submission of this claim, must have the policy number written in the top right hand corner of the documentation
- You or your legal representative have signed the claim form

As failure to do so will result in delay in handling your claim. Please return the completed claim form together with any enclosures to:

**MEDCARE 24
For the Attention of the Claims Manager**

Physical Address : 4 Henri Street, Corner Henri & Smit Street Braamfontein
 Postal Address : P.O. Box 32328, Braamfontein, 2017
 Telephone no. : (011) 339-1508
 Fax No. : (011) 339 1509

Thank you for completing this claim form in full.



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