African Bank

CLAIM FORM: CREDIT LIFE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of deceiving the company. Penalties may include imprisonment, fines and denial of the insurance benefit. African Bank is a registered credit and financial services provider.

PLEASE MARK IN THE APPROPRIATE BOX FOR THE RELEVANT CLAIM

DEATH CLAIM

DEATH CLAIM ☐

Complete the following section: A

The following documents should be included:

- ☐ Certified copy of Death certificate
- ☐ Certified copy of Deceased ID

DISABILITY CLAIM

DISABILITY CLAIM ☐

Complete the following section: A + D + E

The following documents should be included:

- ☐ Certified copy of Client's ID
- ☐ Certified copy of Termination Letter
- ☐ A copy of a medical report with the doctors stamp

RETRENCHMENT CLAIM

RETRENCHMENT INSTALMENT CLAIM (initial claim) ☐

Complete the following section: A + B

The following documents should be included:

- ☐ Certified copy of Client's ID
- ☐ Certified copy of Retrenchment Letter

RETRENCHMENT SETTLEMENT CLAIM (unemployment longer than 6 months) ☐

Complete the following section: A + B

The following documents should be included:

- ☐ Certified copy of Client's ID
- ☐ Affidavit (declaring current employment status, 6 months from retrenchment)
- ☐ Bank statements (6 months from retrenchment)

RETRENCHMENT RE-EMPLOYMENT CLAIM (re-employment within 6 months) ☐

Complete the following section: A + B

The following documents should be included:

- ☐ Certified copy of Client's ID
- ☐ Employment confirmation

continue to right side

SHORT TIME/ TEMPORARY LAYOFF ☐

Complete the following section: A + C

The following documents should be included:

- ☐ Certified copy of Client's ID
- ☐ Letter from employer
- ☐ Pay slip prior to event
- ☐ Pay slip/s during event

SECTION A
Insurance detail

CLIENT DETAIL

Loan account number/s

Insured surname and full names

Postal address

Postal code

Contact telephone number

Signature of client/ next of kin: _____ **Date:** _____

SECTION B
To be completed by employer

RETRENCHMENT CLAIM

Name of employer

Telephone no. of employer

Postal address of employer

Postal code

COMPANY STAMP

Date employed by employer D D M M Y Y Y Y

What was the last date you attended work? D D M M Y Y Y Y

What was the employee's occupation immediately before retrenchment/ redundancy?

What basis employed ☐ Permanent ☐ Contract ☐ Temporary

Reason for loss of employment

Retrenchment	Redundancy	Voluntary retrenchment	Resignation	Dismissal	Liquidation	Expiry of contract

Has the employee been offered an alternative position in your company/ group ☐ Yes ☐ No

DECLARATION BY EMPLOYER

I hereby declare that the answers given by me on this document are true and correct and that no material information has been neither withheld, nor relevant circumstances omitted.

**Please provide a copy of the official retrenchment letter.*

Company official name: _____

Date completed: _____

Telephone number: _____

Signature: _____

continue on page 2

SECTION C
To be completed by employer

SHORT TIME/ TEMPORARY LAYOFF

Name of employer

Telephone no. of employer

Postal address of employer

Postal code

COMPANY STAMP

Date employed by employer D D M M Y Y Y Y

Is the employee on SHORT TIME or TEMPORARY LAYOFF?

When did the short time/ temporary layoff start? D D M M Y Y Y Y

Is the employment receiving lesser income as a result? ☐ Yes ☐ No

When will normal working conditions resume? D D M M Y Y Y Y

DECLARATION BY EMPLOYER

I hereby declare that the answers given by me on this document are true and correct and that no material information has been neither withheld, nor relevant circumstances omitted.

**Please provide a copy of the official retrenchment letter.*

Company official name: _____

Date completed: _____

Telephone number: _____

Signature: _____

SECTION D
To be completed by employer

DISABILITY CLAIM

Details of employment

Name of employer

Period of employment

Capacity

Did the life insured attend work regularly? ☐ Yes ☐ No

Describe the exact nature of duties if possible (Please attach job description)

Was he/ she employed permanently on the date of disablement? D D M M Y Y Y Y

If "no", give full particulars

Is he/ she presently employed in any capacity whatsoever? ☐ Yes ☐ No

If "yes", please state in what capacity

DETAILS OF RENUMERATION

Is any renumeration payable to him/ her as a result of the disability? ☐ Yes ☐ No

Has any renumeration been paid by your company? ☐ Yes ☐ No

If "yes", please state nature

Amount R Term

From any other source? ☐ Yes ☐ No

If "yes", please state nature

Amount R By whom?

continue to right side

SUSPENSION/ TERMINATION OF EMPLOYMENT

Date of disablement D D M M Y Y Y Y

Cause of disablement

GENERAL

Is the disability as a result of a motor vehicle accident? ☐ Yes ☐ No

In your opinion, is he/ she able to do any other type of work for remuneration? ☐ Yes ☐ No

Is so, what type of work?

DECLARATION BY EMPLOYER

I declare that the answers given by me on this document are true and correct to the best of my knowledge and believe that I have not withheld any material information which could influence a decision on this claim.

Company official name: _____

Date completed: _____

Telephone number: _____

Signature: _____

COMPANY STAMP

SECTION E
To be completed by attending medical examiner

DISABILITY CLAIM

Details of insured's medical condition

How long have you know the life insured professionally?

When were you first consulted with regards to insured's present medical condition? D D M M Y Y Y Y

On what date did this condition arise? D D M M Y Y Y Y

Please give full details concerning the cause of condition?

Please give a full description of the life insured's present physical and mental state

What treatment is the life insured at present receiving and to what degree will further treatment relieve the symptoms?

Please provide the date and names of hospitals or clinics where treatment received.

Name of hospital/ clinic	Date
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

Is any further treatment or are any operations being considered? ☐ Yes ☐ No

If "yes" please provide full details

Please state the names and addresses of any other doctors who treated the life insured for his present condition

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SECTION E (continue)
To be completed by attending medical examiner

Have you previously treated the life insured for any other physical or mental condition relating to the present illness? ☐ Yes ☐ No

If "yes" please state the dates on which the conditions started, the dates the treatment and the nature of treatment.

Nature of treatment	Date condition started	Date of treatment
	D D M M Y Y Y Y	D D M M Y Y Y Y
	D D M M Y Y Y Y	D D M M Y Y Y Y
	D D M M Y Y Y Y	D D M M Y Y Y Y

DETAILS OF INSURED'S INCAPACITY

What is the life insured's normal occupation?

What part of the duties of the life insured's normal occupation is he capable of carrying out?

Is the insured able to follow another occupation? ☐ Yes ☐ No

If "yes" please give examples of such occupations:

Has the excessive use of alcohol or drugs contributed to the present condition? ☐ Yes ☐ No

DECLARATION BY DOCTOR

I hereby declare that, to the best of my knowledge, the information in this report is accurate and complete and that I have not withheld any information which could influence a decision regarding this claim.

Signature of Medical Examiner _____

Date completed: _____

Full name

Physical address

Practice number

Postal code

Practice number

Qualifications D D M M Y Y Y Y

MEDICAL PRACTITIONER