

## 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

Contact telephone number

Postal code

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

Date employed by employer

What was the last date you attended work?

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

What basis employed  Permanent  Contract  Temporary

Reason for loss of employment

COMPANY STAMP

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: \_\_\_\_\_

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**SHORT TIME/ TEMPORARY LAYOFF**

Name of employer

Telephone no. of employer

Postal address of employer

Postal code

Date employed by employer

Is the employee on SHORT TIME or TEMPORARY LAYOFF?

When did the short time/ temporary layoff start?

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

When will normal working conditions resume?



**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: \_\_\_\_\_

**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?

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 remuneration payable to him/ her as a result of the disability?  Yes  No

Has any remuneration 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

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**

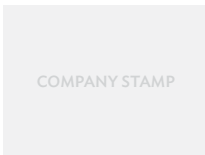
I declare that the answers given by me on this document are true and correct to the best of my knowledge and believe that I have not withheld any material information which could influence a decision on this claim.

Company official name: \_\_\_\_\_

Date completed: \_\_\_\_\_

Telephone number: \_\_\_\_\_

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



**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?

On what date did this condition arise?

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
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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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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
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**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

