



**OLD MUTUAL**

# Death/Disability Benefit Request - Group Schemes

**Branch**

**Branch Tracking/Workflow No**

**Date & Time**

## Personal and Address Information (Policyholder)

Name:  
Identity Number:  
Directory Id:  
Gender:

Address:

**Contact Details:**

Home: Cell:  
Work: Fax:  
Email address:

## Claimant/Beneficiary Details

Policy Number \_\_\_\_\_

Prefix \_\_\_\_\_ Initials \_\_\_\_\_ First Name \_\_\_\_\_ Surname \_\_\_\_\_

Date of Birth \_\_\_\_\_ Identity Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Postal Address : \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Telephone (H)

(\_\_\_\_\_) \_\_\_\_\_  
Telephone (W)

Telephone (C) \_\_\_\_\_

Postal Code \_\_\_\_\_

## Details of Deceased/Disabled

Relationship to policyholder : \_\_\_\_\_

Prefix \_\_\_\_\_ Initials \_\_\_\_\_ First Name \_\_\_\_\_ Surname \_\_\_\_\_

Identity Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Death \_\_\_\_\_

Cause of Death/Disability:  
 Accidental  
 Non-Accidental

Cause of Death/Disability

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Tuberculosis (TB) (22) | <input type="checkbox"/> Flu/Pneumonia/Respiratory (6) | <input type="checkbox"/> Intestinal/Stomach (8) | <input type="checkbox"/> HIV/AIDS (92),<br>Brain-related (3) |
| <input type="checkbox"/> Cancer/Tumour (4)      | <input type="checkbox"/> Heart-related (5D)            | <input type="checkbox"/> Diabetes (7K)          |  |
| <input type="checkbox"/> Other (53)             |  |   |  |

## Payment Instruction (of Beneficiary if available)

- Electronic Transfer       Cheque Collection       Posting

Payee  Account Holder/Payee

Addressee  Branch Code

Address  Account Number

Account Type

I, the undersigned, declare that all the information provided in this document is complete and accurate. I agree that the reasons for approving/declining this Benefit Request has been explained to me.

I, the undersigned, hereby request Old Mutual to post the cheque to the address given or deposit the proceeds into the banking account provided. I hereby absolve Old Mutual from any risk or liability resulting in the cheque being lost in the post or the proceeds deposited into the incorrect bank account.

Claimant Signature \_\_\_\_\_

Date \_\_\_\_\_