FAMILY COVER BENEFIT CLAIM FORM (MEMBERS ONLY)

Insurance Contract underwritten by Old Mutual

GUIDELINES FOR COMPLETING THIS FORM

1. Complete the application form fully and in detail as it gives us important information.
2. Use the checklist below to ensure you provide us with all the necessary documents.
3. If you are a beneficiary and wish to deal with Old Mutual directly about your claim or require assistance, please contact us using the details below.

SCHEME DETAILS

Scheme name **MIBCO - Auto Workers Provident Fund** Scheme code 9 5 9 5 2

Employer name

EMPLOYEE DETAILS

First name(s)

Surname

Identity number Date of birth D D M M Y Y Y Y

REQUIREMENTS

DOCUMENTS REQUIRED
Copy of death certificate, (If a handwritten abridged death certificate is submitted, this must be accompanied by a letter from the Department of Home Affairs with the reason why a handwritten abridged death certificate was provided)
Notification of death - all 3 pages (DHA 1663/BI 1663)
Police report for unnatural/accidental deaths
Copy of employee's identity document
Employee's latest payslip
Completed Family Cover Benefit Claim Form (this form)
Completed Beneficiary Nomination Form for family cover benefits
Beneficiary's bank statement and copy of identity document

DETAILS OF EMPLOYEE'S DEATH

Date of death D D M M Y Y Y Y

Main cause of death

PROTECTION OF PERSONAL INFORMATION DISCLOSURE

The Old Mutual Group may use, share or obtain personal information (including criminal and/or health information) for the following purposes:

- Underwriting
- Assessment and processing of claims
- Where applicable, credit reference searches or verification, credit scoring and assessment and credit management
- Verification of personal information (including identity, address and banking details)
- Updating member/lives assured personal information
- Claims checks (Industry Life and Claims Register(s))
- Tracing beneficiaries
- Tracing you where you are uncontactable
- Prevention and detection of fraud, crime, money laundering (including anti-money laundering screening) or other malpractice
- Market or customer satisfaction research or statistical analysis
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements and in connection with legal proceedings
- Sharing information with service providers we engage to process such information on our behalf or who render services to us. These service providers may be abroad, but we will not share your information with them unless we are satisfied that they have adequate security measures in place to protect personal information.

You agree that Old Mutual may view, search and update your information.

All members/beneficiaries may access their personal information that we hold and may also, under certain circumstances, request us to correct any errors or to delete this information. In certain cases they have the right to object to the processing of their personal information.

You also have the right to complain to the Information Regulator, whose contact details are:
Website: www.justice.gov.za/inforeg/index.html
General enquiries: enquiries@inforegulator.org.za
Complaints: popiacomplaints@inforegulator.org.za

To view our full privacy notice and to exercise your preferences, please visit our website on www.oldmutual.co.za/privacy-policy/

EMPLOYER/CLAIMANT DECLARATION

I, _____ the undersigned, in my capacity as _____ and duly authorised to make this declaration, hereby declare:

a) That the information provided in this claim is true and correct, and that no information has been omitted or withheld
b) That the insured person whose death gave rise to this claim has in fact died
c) That payment of the proceeds, due in respect of the above insured person in terms of the aforementioned policy, shall represent the full and final discharge of Old Mutual Group Assurance's liability in respect of this insured person
d) The employer is up to date with all provident fund contributions and in good standing with Motor Industry Bargaining Counsil (MIBCO).

I indemnify Old Mutual Group Assurance against any claim that may arise from any incorrect information provided in this form.

Signed at _____ on this _____ day of _____ 20

Full name _____

Designation/Relationship to employee _____

Cellphone number _____

Email address _____

Signature _____

BENEFICIARY DETAILS

Please select ONE option below:

a) The most current nomination form for group family benefits has been attached to this claim application ☐

b) If no nomination form can be located from the deceased, please select one option below:

- There is no immediate family member (this benefit will be paid into the deceased's estate) ☐
- There is an immediate family member (either surviving spouse, child over the age of 18/legal guardian of minor child, parent, brother or sister). Please provide details below. ☐

First name(s)

Surname

Identity number

Relationship to the employee

Email address

Cellphone number

PAYMENT DETAILS

Please provide the account details of the beneficiary on the nomination form; OR the next of kin; OR the deceased's Estate according to the option selected above.

Account holder's name

Bank name

Account number

Branch/SWIFT code

A NOTE TO BENEFICIARIES

Please indicate whether you consent to Old Mutual:

☐ communicating with the policy holder, OR

☐ communicating with you directly, using the details provided below:

First name(s)

Surname

Email address

Cellphone number

You are welcome to contact us at 021 509 4351 should you require assistance with completing and submitting this form.

Submit the form by email:
Email gapdeathclaims@oldmutual.com

MIRF Auto Workers Provident Fund

Underwritten by OLDMUTUAL