OLD MUTUAL SUPERFUND

OLDMUTUAL

CORPORATE

DEATH BENEFIT CLAIM FORM 5 ABOUT THE DEPENDANTS WHO DO NOT WISH TO CLAIM

For reference purposes:	
Name and Surname of the Deceased (as per the ID book)	
ID or Passport Number of the Deceased	

This is Claim Form 5 and should be completed by an adult who is a dependant of the Deceased, but who **does not wish to claim or receive any benefits from the Fund.**

If you need help filling in this form, please call 0860 388 873. Please return these forms to the Claims Department:

Old Mutual SuperFund
PO Box 728, Cape Town 8000, South Africa.

Tel: 0860 203 040
Fax: 021 509 4677 or 021 509 6271
Email: SuperfundDeathsQueries@oldmutual.com

Please attach a certified copy of your ID to this form.

PLEASE NOTE THAT FOR THE ALLOCATION OF DEATH BENEFITS, THE FOLLOWING PERSONS QUALIFY AS DEPENDANTS IN TERMS OF THE PENSION FUNDS ACT:

- A spouse, who concluded a customary marriage, civil marriage, registered civil union or marriage in accordance with a widely recognised religion
- Children (biological, legally adopted and children born outside of marriage)
- Anyone proven to be factually dependent on the Deceased for maintenance/ financial support at date of death
- Anyone to whom the Deceased was legally liable for maintenance/financial support (e.g. in terms of divorce agreements and maintenance orders) or would have become legally liable for maintenance, had the deceased not died (e.g. engaged to be married, unborn children)

NB: The definition of a "dependant" as it appears in the Pension Funds Act, is not set out here. Please consult the Pension Funds Act should you not be clear as to whether you are a dependant or not

A SWORN STATEMENT BY THE PERSON FILLING IN THIS FORM

This section must be signed in front of a Commissioner of Oaths.

I, _____ (full names and surname) declare under oath, in full knowledge of my rights, that I do not want to claim from or be paid any benefit by the Fund arising from the death of the Deceased and waive any right I might have to such benefit. I confirm that I have been informed that I might qualify to be paid a portion of the death benefit and understand that **by signing this form, I will not receive a portion of the death benefit**.

Identity number		**Telephone**	
Address		**Email address**	
The reason I do not wish to receive any portion of the benefit:			
Signed at (place)		**Date signed**	
Signature of the person waiving their right to claim or be paid any benefit			

B STATEMENT BY A COMMISSIONER OF OATHS

The person mentioned above has signed this Form in front of me. They have stated that they know and understand the contents of this affidavit. They have confirmed that they have no objections to this oath, and that the oath is binding on their conscience.

Commissioner of Oaths: Full name and surname			
Telephone		**Designation**	
Signature of Commissioner of Oaths		**Official stamp**	