OLD MUTUAL SUPERFUND FAMILY BENEFIT CLAIM FORM

GUIDELINES FOR COMPLETION OF THIS FORM

The following guidelines will help Old Mutual SuperFund to process your claim quickly and accurately:

1. These claim forms must be completed by an authorised representative of the employer
2. Complete the application form fully and in detail as it gives us important information
3. Write your answers in clear black or blue block letters so that it is easy to read
4. If the form is completed electronically, please print, sign, stamp and scan the form to send to us
5. Use the checklist below to ensure that you hand in all the necessary documents

Documents required	**Tick (✓)**
Copy of death certificate, certified by a Commissioner of Oaths or the SAPS • 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/stillbirth form (DHA 1663/BI 1663) (in the case of a stillborn child, ensure that section G of this form is included)	
Police report for unnatural/accidental deaths	
Certified copy of the member's identity document	
Bank statement and certified copy of beneficiary's identity document (ONLY if payable to beneficiary)	
Claim application form completed by the authorised representative of the employer	

Additional documents required if the deceased is an insured family member	**Tick (✓)**
Certified copy of insured family member's identity document/unabridged birth certificate	
Proof of relationship to the member: • Certified copy of marriage certificate, **OR** • Employer records, Beneficiary Nomination Form or Medical Aid Nomination Form, **OR** • Declaration from a third party confirming the duration of the relationship, on a formal letterhead, signed and stamped, e.g. Tribal Chief, Minister of Religion (for an insured spouse – only if the above is not available) • Affidavit from the other parent/third party confirming the relationship between the child and the member, e.g. biological, adopted or stepchild (only if the above is not available)	

Submit the form electronically, by fax or post:

Email superfundfuneralclaimqueries@oldmutual.com

Fax 0860 383 848

Address Old Mutual SuperFund
Death Claims Team
Old Mutual
PO Box 728
Cape Town 8000

You are welcome to contact us at 0860 20 30 40 should you require assistance with completing and submitting this form.

PROTECTION OF PERSONAL INFORMATION DISCLOSURE

The Fund will provide you with ongoing communication and information about Fund related products or services that may be suitable to meet your Fund related financial needs.

We may use your information or obtain information about you for the following purposes:

- Underwriting in respect of Fund risk benefits
- Assessment and processing of Fund benefit claims
- Member communication
- Verification of personal information
- Claims checks (industry Life and Claims Register)
- Tracing beneficiaries
- Fraud prevention and detection
- Market research and statistical analysis
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements
- Verifying your identity
- Updating your personal information
- Sharing information with service providers we engage to process such information on our behalf or who render services to the Fund. 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 your personal information.

You may access your personal information that we hold and may also request us to correct any errors or to delete this information. In certain cases you have the right to object to the processing of your personal information.

You also have the right to complain to the Information Regulator, whose contact details are:
http://www.justice.gov.za/inforeg/index.html
Tel: 012 406 4818
Fax: 086 500 3351
Email: inforeg@justice.gov.za

Please visit our Secure Services website on secure.dcc.oldmutual.co.za/omlogin.aspx and access '"Self Service" under "My Portfolio" to exercise your preferences.

To view our full privacy notice, visit oldmutual.co.za/corporate/retirement-funds/superfund-privacy-policy

EMPLOYER DECLARATION AND AUTHORITY TO PAY CLAIM

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 scheme below, shall represent the full and final discharge of Old Mutual's liability in respect of this insured person

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

I hereby instruct Old Mutual SuperFund to pay the Family Cover benefit as per the payment instruction below.

Signed at _____ on this _____ day of _____ 20

Name _____

Telephone: code _____ number _____

Email address _____

Signature _____

OFFICIAL COMPANY STAMP

SCHEME DETAILS

Scheme name _____ Scheme code _____

Participating Employer's name _____

MEMBER DETAILS

First name(s) _____

Surname _____

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

Date of joining employer D D M M Y Y Y Y

Date of joining scheme D D M M Y Y Y Y

Date of member's death D D M M Y Y Y Y

Main cause of death _____

DECEASED PERSON'S DETAILS – COMPLETE ONLY IF THE DECEASED IS AN INSURED FAMILY MEMBER

First name(s) _____

Surname _____

Identity number _____

Date of birth D D M M Y Y Y Y Date of death D D M M Y Y Y Y

Gestational age of foetus _____ weeks Relationship to the member _____

Main cause of death _____

PAYMENT DETAILS

- In terms of the Family Benefit policy contract, Old Mutual must pay the benefits strictly in accordance with the written confirmation and instruction from the Employer/Proposer
- The benefit will be electronically transferred to the relevant bank account in terms of the Policy Contract
- Benefit payable to: _____
- If the benefit is payable to an international bank account, please provide the International Bank Account Number (IBAN) and SWIFT Bank Identifier Code (SWIFTBIC)

Bank account details

Name of account holder _____

Identity number _____ Account number _____

Name of bank _____ Branch/SWIFT code _____

Beneficiary contact details for confirmation of payment

Email address _____

Cellphone _____

OLDMUTUAL