ACCIDENTAL DEATH CLAIM FORM

CLAIMING PROCEDURES

Please complete claim form, attach all necessary correspondence and send it to Unity Health:

Unity Health
PO Box 1862, Cramerview, 2060 Fax: 011 706 5568
Email: caseman@unityhealth.co.za

PRINCIPAL INSURED MEMBER DETAILS

SURNAME		INITIALS	
I.D NUMBER		POLICY/MEMBER NUMBER	

CONTACT DETAILS

POSTAL ADDRESS			PHYSICAL ADDRESS (IF DIFFERENT TO POSTAL)		
POSTAL CODE			POSTAL CODE		
HOME NUMBER	AREA CODE		WORK NUMBER	AREA CODE	
CELL NUMBER	AREA CODE		E-MAIL		

DETAILS OF CLAIM

DECEASED DETAILS

SURNAME		FIRST NAMES	
I.D NUMBER		RELATIONSHIP OF MAIN MEMBER	

CAUSE OF DEATH

STATE EXACT CAUSE OF DEATH

DATE OF DEATH	

DETAILS OF HOSPITAL ADMISSION (if applicable)

HOSPITAL NAME		CONTACT NUMBER	AREA CODE	
DATE ADMITTED		NAME		
NAME AND ADDRESS OF DOCTOR WHO SIGNED BI 1663 HOSPITAL FORM		ADDRESS		
		POSTAL CODE		

#StayHealthy

POLICE REPORT, IF UNNATURAL CAUSES (attach copy of report)

POLICE STATION WHERE REPORTED		CASE NUMBER	

CLAIMANT OR BENEFICIARY DETAILS

SURNAME		INITIALS	
I.D NUMBER			
RELATIONSHIP TO PRINCIPLE INSURED			

CONTACT DETAILS

HOME NUMBER	AREA CODE		WORK NUMBER	AREA CODE	
CELL NUMBER	AREA CODE		E-MAIL		

CLAIMANT DECLARATION

I hereby declare that the person mentioned under claim details is nominated under the abovementioned policy, that all the particulars given are true and complete, and that his / her / my incapacitating condition was not wholly or partly, directly or indirectly caused by the contingencies mentioned in the exclusions under the conditions of the disability provisions attached to the policy in question.

I further declare that the above statements and answers to the questions under the relevant sections are true and completed in full, that I/we have not withheld any material information and that I/we undertake to furnish any documentation which may be required by the Insurer. I expressly waive all provisions of law, custom or professional etiquette forbidding any physician or any other person attended or examined the patient/deceased or any institution in which the patient/deceased received treatment to disclose any knowledge or information which was thereby acquired and I/we authorise all such persons or agencies to furnish any information in their possession to the Insurer or its authorised representative.

I hereby authorise any hospital, physician or other person who has attended or examined me or my dependants to furnish to Unity Health, Bryte Insurance Company Limited or its authorised representative, any information with respect to any illness or injury medical history consultation prescriptions or treatment and copies of all hospital or medical records.

SIGNATURE OF CLAIMANT	SIGNATURE OF WITNESS	DATE	

PAYMENT INSTRUCTIONS

BENEFITS TO BE PAID INTO MY BANK ACCOUNT BY ELECTRONIC FUND TRANSFER, DETAILS BELOW					
ACCOUT HOLDERS NAME		BANK			
ACCOUNT NUMBER		BRANCH			
BRANCH CODE		ACCOUNT TYPE			CURRENT
(NO CREDIT CARD ACCOUNTS ACCEPTED)					TRANSMISSION
					SAVINGS
THE COMPANY WILL NOT BE LIABLE FOR THE LOSS OF FUNDS DUE TO THE PROVISION OF INCORRECT BANK DETAILS.					

FUNERAL BENEFIT CLAIM

THE FOLLOWING DOCUMENTS MUST ACCOMPANY THIS CLAIM FORM – WHICH MUST BE FULLY COMPLETED		
1. ORIGINAL DEATH CERTIFICATE WHERE POSSIBLE (CERTIFIED COPY WILL BE ACCEPTED)		
2. POLICE REPORT IF APPLICABLE.		
3. CERTIFIED COPIES OF IDENTITY DOCUMENTS.		

USE OF PERSONAL INFORMATION DECLARATION

I hereby consent to Unity Health processing my personal information, including but not limited to, the administrative functions listed below.

- Processing this request;
- Processing of future instructions submitted;
- Communications with me in relation to any matters in relation to my policy.

I consent to Unity Health disclosing and transferring my personal information to any contracted third party for the purposes of collecting premiums, claim assessments and statutory reporting in connection with this contract.

I acknowledge I have the right to:

- Object to the processing of my personal information on reasonable grounds unless legislation allows for such processing, in the manner prescribed by the POPI Act;
- lodge a complaint with the Information Regulator;
- request from Unity Health details of any of my personal information Unity Health holds on my behalf and details of how my personal information has been processed.

Unity Health will use its best endeavours to ensure your personal information is reliable, however it remains your responsibility to advise Unity Health of any changes to your personal information in a timely manner. The information supplied to Unity Health must be complete, correct and up to date.

I understand why my personal information is required and the purpose it will be used and I, hereby, give Unity Health consent to process my personal information as provided above.

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