ZB LIFE ASSURANCE LIMITED

CASH FUNERAL CLAIM DISCHARGE FORM

(TO BE COMPLETED IN FULL AND FOR USE ON ALL CASH FUNERAL PRODUCTS)

POLICY NO. _____ BRANCH (where claim is submitted)._____
Contact Person and Telephone: _____

I hereby advise that the person whose details are shown below has died. I now hereby make application for the payment of monies due under the policy.

1. DETAILS OF DECEASED

Surname | Forenames

National Registration Number | Date of birth

Place of Death | Date of death

Cause of death (tick appropriate box and supply details)

☐ Natural Causes: Actual cause(s) of death.....

☐ Accident: Details and Police station handling the case and reference number.....

.....

☐ Suicide

Burial Order/Death Certificate Number

When did the health of the deceased begin to be affected?

2. DETAILS OF PERSON(S) CLAIMING

Full Names

National Registration Number | Relationship to Deceased

In what capacity do you make this claim e.g. policyholder, surviving spouse, parent, dependant, child, brother, sister, etc.?

Address

Telephone Number

Mobile Number | E-mail Address

Social Media Contact details (specify).....

Claim Settlement Options (Please tick appropriate box)

☐ Please pay full claim proceeds to .....
(Name of Service Provider)

☐ Please pay ..... of the claim proceeds to ..... and the balance to me
(Fixed amount or percentage) (Name of Service Provider)

☐ Please pay the full claim proceeds to me

My/Our banking details are Bank Name :.....
Account Number :.....
Account Name :.....

3. **DETAILS OF FUNERAL SERVICES REQUESTED**

	SERVICE REQUIRED	Please tick approp riate box		COST
1	Body removal	Yes	No	
2	Mortuary Services	Yes	No	
3	Coffin/Casket	Yes	No	
4	Dressing	Yes	No	
5	Hearse	Yes	No	
6	Transport services	Yes	No	
7	Chapel Services	Yes	No	
8	Burial Services	Yes	No	
9	Other (please specify.....	Yes	No	
	.....	Yes	No	

4. **SUPPLEMENTARY BENEFITS**

Supply instructions for payment of the Supplementary Benefits attached to the policy. Note that this is only applicable if the Supplementary Benefit is available on the policy.

a) Memorial Cash Benefit:

☐ Pay after .....months (not more than 3 months)

☐ Pay together with the basic cover

b) Tombstone Cash Benefit: Pay after .....months (between 12 to 18 months)

c) Grocery Benefit: Pay to (beneficiary's full name).....

Bank..... Branch.....

Account number.....

d) School Fees Benefit: Pay to (can be a school/education institution).....

Bank..... Branch.....

Account number.....

5. **DECLARATION (IMPORTANT - Please read carefully before signing)**

I/We, the undersigned, do hereby solemnly and sincerely declare that all the foregoing statements are true and correct to the best of my/our knowledge and belief.

I/We understand that any false, incomplete or misleading statements will leave me/us liable to criminal and civil legal action including the repayment of the monies paid to me plus interest at the ruling interest rate.

SIGNATURE _____**DATE**_____