OLD MUTUAL

CLAIM FORM FOR GROUP LIFE ASSURANCE

Name of the member _____ *Staff Membership/Payroll No* _____

Date of Event leading to claim _____ *Place of Event*_____

*Cause of the claim*_____

If Illness, state duration of illness _____ *Date last worked for employer*_____

Occupation at time of Event _____ *Dept./Station at time of Event* _____

TYPE OF CLAIM

Death	☐	Accidental Death	☐
Accidental PTD	☐	Accidental TTD	☐
Medical Reimbursement	☐	Critical Illness claim	☐
Funeral Benefits	☐		

EMPLOYER'S STATEMENT

Notice is hereby given of the death of the above referred member, an employee of this company, who was insured under Policy Number _____ *and who entered our employment on* _____.

We hereby warrant that the said employee was in our employment at the time of death /injury and on our payroll continuously from the date he/she entered the scheme. We also declare that all facts declared hereto are true to the best of our knowledge and belief.

Name _____	Name _____
Occupation _____	Occupation _____
Signature_____	Signature _____
Date _____	Date _____

***** Kindly impress the organization's official stamp***.**

Old Mutual Life Assurance Company Limited.
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