Stratum Benefits

2024 HEALTH INSURANCE ACCIDENTAL DEATH CLAIM FORM

1. PRINCIPAL INSURED DETAILS

Policy No.

Title | Name | Surname

ID/Passport No. | Date of Birth Y Y Y Y - M M - D D

Cellphone No. | Alternative Contact No.

Physical Address | Postal Code

Email Address

2. DETAILS OF THE DECEASED

Name | Surname

ID/Passport No. | Date of Birth Y Y Y Y - M M - D D

Relationship to Principal Insured

3. CAUSE OF DEATH

Where possible, attach a copy of the original death certificate or a certified copy. If the exact cause of death is not on the certificate, please state it.

Date of death Y Y Y Y - M M - D D | Place of accident

4. HOSPITAL ADMISSION DETAILS

If the death occurred during hospitalisation, please provide the details below.

Name of Hospital

Contact No. | Date Admitted Y Y Y Y - M M - D D

Please provide the name and address of the healthcare provider who signed the **BI-1663 Hospital Form**.

Name | Surname

Physical Address | Postal Code

5. POLICE REPORT DETAILS

If death was due to unnatural causes, please attach a copy of the police report.

Police station where reported

SA Police Case No.

6. BENEFICIARY DETAILS

Please attach a certified copy of the beneficiary's identity or passport document

Title | Name | Surname

ID/Passport No. | Date of Birth Y Y Y Y - M M - D D

Home No. | Work No.

Physical Address | Postal Code

Email Address | Relationship to Deceased

7. BENEFICIARY DECLARATION

I declare that all the particulars provided herein, statements and answers are true and correct and have been completed to the best of my knowledge and understanding.

I haven't withheld any material information and undertake to furnish applicable documentation to the Insurer as required.

I waive all provisions of law, custom or professional etiquette forbidding any physician or any other person who attended to or examined the deceased or any institution where the deceased received treatment to disclose any knowledge or information acquired during such treatment. I authorise all such persons, agencies or institutions to furnish any information in their possession to the Insurer or its authorised representatives is required.

I authorise any institution, hospital, physician or other applicable third parties who have attended to or examined the deceased to furnish **Unity Health**, the Insurer or its authorised representatives with any information about any illness, injury, medical history, consultation, prescription or treatment of the deceased, together with copies of all such hospital or medical records and other applicable documentation, as may be required.

I authorise **Unity Health**, the Insurer and its authorised representatives to make the payment as was asked above. I acknowledge that such payment to me will release **Unity Health**, the Insurer and its authorised representatives from all liability for these benefits after receiving such payment.

8. PAYMENT DETAILS

Please submit a bank verification letter dated not older than **3 months**.

I, the beneficiary in terms hereof, consent to the benefits being paid into my bank account as provided below.

I acknowledge and accept that **Unity Health**, the Insurer and its authorised representatives attending to the processing of the payment of benefits are indemnified from any loss caused by me if such funds are paid, and the banking details as shown here are incorrect.

Bank		Account No.	
Account Holder		Branch	
Account Type	Cheque Saving	Account Holder Signature	

9. USE AND PROCESSING OF PERSONAL INFORMATION DECLARATION

I consent to the following:

1. **Unity Health**, the Insurer and its authorised representatives may obtain and process my personal data. I understand why personal data is required and the purpose for which it will be used.
2. **Unity Health**, the Insurer and its authorised representatives are to attend to the following administrative functions, but not limited to only the listed functions:
   - processing this request;
   - processing future instructions relating hereto as may be required and duly submitted; and
   - communicating with me about any matters relating to my policy.
3. **Unity Health**, the Insurer and its authorised representatives to disclose and transfer my personal data to any contracted third party for this claim, assessment thereof and for statutory reporting.

I acknowledge and understand that I have the right to:

- object to the processing of my personal data on reasonable grounds unless legislation allows for such processing in the manner as prescribed by the POPI Act;
- lodge a complaint with the Information Regulator; and
- request from **Unity Health** details of any of my personal data which they hold on my behalf, as well as the processing of my data, either past, present or future.

Unity Health will use its best efforts to ensure your personal data is reliable.

You must inform **Unity Health** of changes to your personal details as soon as possible. Information given to **Unity Health** must always be complete, correct and up to date.

10. BENEFICIARY CONSENT

BENEFICIARY

Name		Surname	
Signature		Date	Y Y Y Y - M M - D D

WITNESS

Name		Surname	
Signature		Date	Y Y Y Y - M M - D D

Send the completed claim form to yoursupport@stratumbenefits.co.za.
Please contact us if you haven't received feedback within **7 working days** from submitting the claim form.