2025 HEALTH INSURANCE ACCIDENTAL DEATH BENEFIT CLAIM FORM | Stratum Benefits

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, submit a copy of the original death certificate or a certified copy. If the cause of death is not confirmed on the certificate, please state it.

Date of Death Y Y Y Y - M M - D D | Place of Accident

4. HOSPITAL ADMISSION DETAILS

Provide the below details if the death occurred during hospitalisation.

Name of Hospital | Contact No.

Date Admitted Y Y Y Y - M M - D D

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

Submit a copy of the police report if the death was due to unnatural causes.

Police station where reported | SA Police Case No.

6. BENEFICIARY DETAILS

Please submit 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. CLAIM PAYMENT DETAILS

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

As the beneficiary, you consent to the benefit being paid into your bank account as provided below.

You accept that **Unity Health**, the Insurer and its authorised representatives attending to the processing of the payment are indemnified from any loss caused if payment is made into an incorrect bank account number provided by you.

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

8. BENEFICIARY ACCEPTANCE

You declare that all the particulars, statements and answers are true and correct and have been completed to the best of your knowledge and understanding.

You haven't withheld any material information and undertake to furnish applicable documentation to **Unity Health**, the Insurer and its authorised representatives as required.

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

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

9. PROTECTION OF PERSONAL INFORMATION

USE OF PERSONAL INFORMATION DECLARATION

By submitting this claim form, you allow **Unity Health**, the Insurer and its authorised representatives to:

1. obtain and process your personal data.
2. attend to the following administrative functions, but not limited to only the listed functions:
   - process this request;
   - process future instructions relating hereto as may be required and duly submitted; and
   - communicate with you about any matters relating to the claim.
3. disclose and transfer your personal data to any contracted third party for this claim, its assessment, and statutory reporting.

You acknowledge and understand your right to:

- object to the processing of your 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 your data they hold and how they process it.

You must inform **Unity Health** of changes to your details as soon as possible. The information you provide must always be complete, correct, and up to date.

Unity Health will try its best to ensure your data is reliable.

Send the completed claim form to us at: **yoursupport@stratumbenefits.co.za**

Please contact us if you haven't received feedback within **7 working days** of submitting the claim form.