



Any cost incurred in the completion of this form will be the responsibility of the Eligible Member or the Beneficiary.

Section 1: Deceased Details			
Name of Eligible Member:			
Membership/Identity Number:		Date of Birth:	
Occupation:		Contact Number (Office):	
Address (Residential):			
Postal Address:			
Beneficiary Details			
Name:		Surname:	Title:
ID Number:		Gender:	☐ Female ☐ Male
Relation:		Email Address:	
Contact Numbers:		Alternative Number:	
Beneficiary's Banking Details			
Name of Account Holder:		Name of Bank:	
Branch Name:		Account Number:	
Branch Code:		Account Type:	
Date:		Signature:	

Section 2: Death Event			
Date of Death:		Place of Death:	Time of Death:
State the cause of death and any other important factors connected therewith by giving a detailed description of how the incident happened:			

PLEASE NOTE THAT YOU HAVE 6 MONTHS FROM THE DATE OF DEATH TO SUBMIT THIS CLAIM.

The following information should be provided as and when it becomes available: (All certified copies must not be more than 3 months old)

- ☐ A. Certified copy of the deceased and beneficiary's ID documents. (Compulsory)
- ☐ B. Certified copies of the abridged or final death certificate. (Compulsory)
- ☐ C. BI 1663 notification of death form, indicating the cause of death. (Compulsory)
- ☐ D. Beneficiary bank statement. (Compulsory)
- ☐ E. Marriage certificate/Affidavit/letter of authority. (Compulsory)
- ☐ F. The police accident report (Only if the death was the result of a motor vehicle accident)
- ☐ G. The police report and/or Statement by Police (if death is due to unnatural causes)
- ☐ H. Other documents may be requested in order to assess the validity of the claim.

ALL INFORMATION CAN BE SUBMITTED TO: funeralclaims@nbcpshealth.co.za



EMAIL ADDRESS FOR GENERAL ENQUIRIES
info@nbcpshealth.co.za



PLEASE CALL ME
060 769 8770



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083 231 6771



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