

FundsAtWork Claim form for Family Protector

Member number

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Please attach the following documents:

- Certified copy of the death certificate.
- Certified copy of the deceased's identity document/birth certificate.
- Copy of the BI 1663 (obtainable from the doctor who certified the death).
- Certified copy of the claimant's identity document/birth certificate.
- If the deceased child does not bear the same surname as the member, proof in the form of an affidavit.
- If the deceased is a spouse, a certified copy of the marriage certificate.
- If a marriage certificate is not available, proof that a permanent life partnership existed, in the form of an affidavit.
- Copy of bank statement not older than three months (no ATM or internet statement will be accepted) or a cancelled cheque.

Please note that the processing of the claim is subject to the following conditions:

- All applicable sections must be completed in full.
- An **approved** Commissioner of Oaths must certify all copies.
- All copies must be legible, and photocopies and certifications must be clear.

Section 1: Employer details

Employer's name

Employee number

Section 2: Member details (compulsory)

Title Initial/s First name

Surname

Date of birth - -

RSA ID Yes No Identity/ Passport number

Passport country of origin

Residential address

 Postal code

Postal address
 Postal code

Telephone - work Fax

Telephone - home Cellphone number

Tax number Tax office

Email address

Section 3: Claimant's details (if different from member)

Title Initial/s First name

Surname

Date of birth - -

RSA ID Yes No Identity/ Passport number

Passport country of origin

Residential address

 Postal code

Postal address
 Postal code

Relationship to the member

Member number

Grid for member number

Section 3: Claimant's details (if different from member) (continued)

Form for Section 3: Telephone - work, Telephone - home, Tax number, Email address, Fax, Cellphone number, Tax office

Section 4: Next of kin to the deceased, other than the claimant (if the member is the deceased)

Form for Section 4: Title, Surname, Date of birth, RSA ID, Passport country of origin, Residential address, Postal address, Telephone - work, Telephone - home, Initial/s, First name, Identity/ Passport number, Postal code, Fax, Cellphone number

Section 5: Deceased's details (if the deceased is the member, complete 'Date of death' only)

Form for Section 5: Title, Surname, Date of birth, Date of death, RSA ID, Passport country of origin, Residential address, Postal address, Initial/s, First name, Identity/ Passport number, Postal code, Fax

Section 6: Payment details for funeral benefit

Form for Section 6: Name of account holder, Name of bank, Account type, Account number, Branch code

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Section 7: Health premium waiver

- The health premium waiver pays the contribution to the member's medical scheme on the member's acceptance of disability by Momentum FundsAtWork (if they have an income or lump sum disability benefit) or on the member's death (if they have a group life benefit).
- Momentum FundsAtWork will make the payment to the medical scheme.
- Annual increases for members on Momentum Health will be covered by the health premium waiver benefit.
- Annual increases on another medical scheme will be capped to the medical inflation rate.
- All claims are subject to receiving the relevant accompanying documentation.

This claim is a result of the member's: Disability Death

Medical scheme details

Name of the medical scheme	<input type="text"/>
Reference number	<input type="text"/>
Option	<input type="text"/>
Number of dependants	<input type="text"/>
Premium paid	R <input type="text"/>

Section 8: Payment details of medical scheme (other than Momentum Health)

Name of account holder	<input type="text"/>
Name of bank	<input type="text"/>
Account type	<input type="checkbox"/> Current/Cheque <input type="checkbox"/> Savings <input type="checkbox"/> Transmission
Account number	<input type="text"/> Branch code <input type="text"/> - <input type="text"/> - <input type="text"/>

Section 9: Declaration by employer

I (full names)

hereby declare that:

- The deceased was a member of the scheme at the date of death or a dependant of a member.
- All particulars furnished in this form and accompanying documentation are true and correct.
- I have made every effort to comply with the requirements stated in this document.

Signed at

Designation

Signature

Date - -

Official stamp of employer

Completed form and accompanying documents to be faxed to 012 675 3970 or emailed to clientcontactcentre@momentum.co.za.

Terms and conditions

1. Momentum FundsAtWork will not be liable for any losses the claimant incurs if the information supplied is unclear, illegible or incorrect in any way.
2. No benefit will be paid if death is as a result of suicide or self-inflicted injury within the first two years of the member flexing their benefit.
3. Momentum FundsAtWork reserves the right to request further documentation/proof before finalising this claim.
4. Notification of a claim must be received within 3 months of the date of death for it to be admitted.
5. All requirements must be received within 4 months for the claim to be paid.
6. All claims are subject to receiving the relevant accompanying documentation as specified at the beginning of this form.