Guardrisk INSURANCE
INNOVATIVE RISK SOLUTIONS

CERTIFICATE NO:

CREDIT PROTECTION INSURANCE - DEATH CLAIM

Insured details:

Full name: _____ ID number: _____

Address: _____

Tel no _____ Cell: _____

Email: _____ Fax: _____

Claimant details

Full name: _____

Address: _____

Tel no: _____ Cell: _____

Email _____ Fax: _____

Relationship to insured: _____ ID number: _____

Finance detail:

Finance company _____ Account number _____

Vehicle Type _____ Vehicle Registration _____

Date vehicle financed _____ Monthly repayment _____

Details:

Date of death _____ Cause of death: Natural ☐ Unnatural ☐

Description of illness/injury/trauma: _____

Did the insured have any pre-existing conditions? Y N

If yes, please give detail: _____

Name and contact detail of doctor who treated deceased at time of death

Name and contact detail of regular doctor of the deceased:

Medical aid scheme and number:

Declaration:

We hereby declare the foregoing particulars to be true in every respect,

The following documents must be submitted with this claim:

1. Copy of death certificate
2. Copy of post mortem report
3. Five year medical report prior to inception of policy
4. If unnatural - Police report
5. Copy of ID document
6. Accident report if vehicle accident
7. Comprehensive insurer details if vehicle accident
8. Letter of executorship
9. Notification of death (B11663) both pages
10. Transaction history from finance institute (inception to date)

*Please note that no claim will be considered with out the 5 year medical reports

I autorise any medical practioner, hospital or other person to provide the appointed agents with any information they may require relating to the medical history for this claim. I agree that this consent shall remain in force at all times, and that a photo-copy or fax of this declaration shall be accepted as the original.

Signature of claimant _____ Signed on DD/MM/YYYY _____ Signature of insured _____ Signed on DD/MM/YYYY _____

(Please send this form to: Fax: 086 218 9202 or Email: claims@nttgroup.co.za or PO Box 35302, Menlopark, 0102)

Office use only

All Premiums paid at date of death: Y N Comment: _____

Assessment of claim assigned to: _____