DEATH AND ACCIDENTAL DEATH BENEFIT CLAIM FORM

NB: This form is to be completed by the Employer.

1. **NAME OF EMPLOYER** : _____

2. **DETAILS OF INDIVIDUAL EMPLOYEE**

FULL NAME : _____

DATE OF BIRTH :_____

OCCUPATION :_____

NORMAL WORKPLACE :_____

DATE OF JOINING EMPLOYMENT :_____

DATE OF ELIGIBILITY TO JOIN SCHEME :_____

DATE OF JOINING SCHEME :_____
(IF DIFFERENT TO FIRST ELIGIBLE DATE, PLEASE EXPLAIN)

If the answer to any of the questions below is **"NO"**, please give the Full Details, Dates and Reasons.

1. WAS THE MEMBER ACTIVELY AT WORK ON THE DATE OF JOINING THE SCHEME? **YES / NO**
2. WAS THE MEMBER ACTIVELY AT WORK ON THE DATE OF THE LAST INCREASE IN INSURED BENEFITS? **YES / NO**

DATE OF DEATH :_____

DATE OF LAST ACTIVELY AT WORK :_____

SALARY AT DATE OF DEATH :_____

INSURED BENEFIT AT DATE OF DEATH :_____

I declare that the statements given above are complete and accurate; that the above Employee was eligible for the Membership of the Scheme and that the Employee was a Member of the Scheme and was in our Employment till the Date of his Death.

SIGNED _____ **POSITION** _____ **DATE** _____
WITH COMPANY SEAL