

FUNERAL CLAIM FORM

FUND NAME: _____



 Administered by **RFS Fund Administrators**

 Cnr. Feld St and Newton St, Windhoek • PO Box 80349, Windhoek, Namibia

Required Documents:

1. Underwriter Funeral claim form
2. Certified copy of death certificate of deceased
3. Certified copy of marriage certificate if applicable (for spouses)
4. Certified copy of ID of the spouse if applicable
5. Certified copy of full birth certificate showing parentage of child if applicable

A MEMBER DETAILS

| | | | | | |
|---------------------------------|------------------|----------|---------|------------------------|---------------|
| Employer / Cost Centre | | | | Company Ref. No | |
| Title, Initials, Surname | Title | Initials | Surname | | |
| First Name | | | | Date of Birth | DD / MM/ YYYY |
| Identity number | New: Namibian ID | | | Other: Passport No | |

B DECEASED DETAILS

| | | | | | |
|---------------------------------|-----------------------|----------|---------|----------------------|---------------|
| Title, Initials, Surname | Title | Initials | Surname | | |
| First Names | | | | Date of Birth | DD / MM/ YYYY |
| Identity number | ID or passport number | | | Date of death | DD/MM/YYYY |
| Relationship to Member | | | | | |

C DETAILS OF PAYEE

| | | | | | |
|---------------------------------|-----------------------|----------|---------------------------------|----------------------|---------------|
| Title, Initials, Surname | Title | Initials | Surname | | |
| First Names | | | | Date of Birth | DD / MM/ YYYY |
| Identity number* | ID or passport number | | Relationship to deceased | | |
| Contact details: | Postal: | | Phone: | e-Mail: | |

D DECLARATION BY CLAIMANT:

I certify that the above information is true and correct and that the funeral benefit due i.r.o the deceased member indicated above will be in full and final settlement of the benefit due by the Fund.

Name / Signature of Member

Date: DD / MMYYY

E AUTHORISED EMPLOYER SIGNATURE

I confirm that the above information accurately reflects the details of the claim.

EMPLOYER
STAMP

Name

Signature

Date