DEATH (NATURAL)
CLAIM FORM

ACCOUNT HOLDER INFORMATION

Surname

First name

ID number of insured

Card account number(s)

Personal Loan account number(s)

CLAIMANT INFORMATION

Name of claimant

ID number

Postal address

Telephone numbers Home Work Cell Fax

Email address

DECLARATION:

I hereby certify that the above details are true and correct.

Signature

D D M M Y Y Y Y

Date

IMPORTANT: DOCUMENTS REQUIRED TO BE ATTACHED TO THIS CLAIM FORM

- [ ] Medical Report (Pg 2)
- [ ] Certified Death Certificate
- [ ] Certified ID

DNat. Aug 13

Ground Floor Liberty Grande Building,
Corner of Voortrekker Road and
Vanguard Drive, Goodwood, 7460

PO Box 111, Goodwood, 7459
Tel: 0861 729 727
Fax: 0861 237 483
email: claims@rcsgroup.co.za

www.rcs.co.za

RCS Cards (Pty) Ltd.
Reg. No. 2000/01789/07
A member of the Foschini Group
FSP Reg. No.: FSP44481
NCR Reg. No.: NCRCP38

MEDICAL REPORT

TO BE COMPLETED BY MEDICAL PRACTITIONER

Surname and names of life insured

ID number of life insured

Date of death

Exact cause of death

Date of first diagnosis D D M M Y Y Y Y

Was the deceased informed of diagnosis? Y N

PLEASE STATE THE RELEVANT DATES

(i.e. prescription of medicines, surgery, physiotherapy, psychotherapy, radiotherapy, hospitalisation, medical advice, regular medical examinations for follow-up purposes, etc.)

DIAGNOSED DATE	NATURE OF ILLNESS, HABITS, TENDENCIES OR EVENTS	TREATMENT AND MEDICATION PRESCRIBED	WHAT WAS PATIENT TOLD?

Signed at D D M M Y Y Y Y

Telephone number

Signature of medical practitioner

Qualifications

Practice number

Surname and initials of medical practitioner

Practising Address

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