

Funeral Claim Form



LIBERTY
In it with you

ADVICE INVEST INSURE HEALTH

Liberty Life Lesotho Limited Reg. No. 50966
Maseru Mall, Unit 39 Maseru, Lesotho
t +266 222 12719
w www.liberty.co.ls

KINDLY ANSWER ALL QUESTIONS IN FULL AND ATTACH SUPPORTING DOCUMENTATION AS LISTED BELOW.

SUPPORTING DOCUMENTS FOR THIS CLAIM (PLEASE ATTACH THE FOLLOWING DOCUMENTS)

- Certified copy of death certificate
- Certified copy of Policyholder's proof of identity
- Certified copy of claimant's proof of identity (If the deceased is the Policyholder)
- Certified copy of deceased's proof of identity (If the deceased is a Dependent)
- Proof of bank details for beneficiary or claimant
- Proof of relationship to policyholder for the deceased (If the deceased is a Dependent)
- Police report for accidental death

Liberty Life reserves the right to call for additional documents where necessary in order to validate the claim

Policy number

POLICYHOLDER DETAILS

Surname	<input type="text"/>	Title	<input type="text"/>
First names	<input type="text"/>	Gender	<input type="text"/> M <input type="text"/> F
ID /Passport number	<input type="text"/>	Date of Birth	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y
Income Tax Number	<input type="text"/>		
Telephone number	<input type="text"/>	Mobile Number	<input type="text"/>
Email address	<input type="text"/>		
Postal address	<input type="text"/>		
		Post code	<input type="text"/>
Residential address	<input type="text"/>		
		Post code	<input type="text"/>
Occupation	<input type="text"/>		
Occupation Industry	<input type="text"/>		

LIFE ASSURED DETAILS

Is the deceased	<input type="checkbox"/> Policy holder	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Parent	<input type="checkbox"/> Extended family		
Surname	<input type="text"/>	Title	<input type="text"/>				
First names	<input type="text"/>	Gender	<input type="text"/> M <input type="text"/> F				
ID /Passport number	<input type="text"/>	Date of Birth	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y				

CLAIMANT'S DETAILS *(Must always be policyholder, except where the policyholder is the deceased)*

Surname	<input type="text"/>	Title	<input type="text"/>
First names	<input type="text"/>	Gender	<input type="checkbox"/> M <input type="checkbox"/> F
ID/Passport number	<input type="text"/>	Date of Birth	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y
Income Tax Number	<input type="text"/>		
Telephone number	<input type="text"/>	Mobile Number	<input type="text"/>
Email address	<input type="text"/>		
Postal address	<input type="text"/>		
		Post code	<input type="text"/>
Residential address	<input type="text"/>		
		Post code	<input type="text"/>
Relationship to policyholder	<input type="text"/>		

CLAIM DETAILS

Date of Birth	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y	Cause of death	<input type="checkbox"/> Natural <input type="checkbox"/> Unnatural
Provide details on the cause of death	<input type="text"/>		
	<input type="text"/>		
If death is due to an accident, was the accident reported to the police?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of police station	<input type="text"/>		
Case number	<input type="text"/>		

CLAIM PAYMENT DETAILS

EFT

BANK DETAILS FOR EFT PAYMENTS

(Please attach a copy of the latest bank statement - must not be older than 3 months, or confirmation of account details on the Bank's letterhead.)

Name of account holder	<input type="text"/>		
Name of bank	<input type="text"/>		
Account number	<input type="text"/>		
Branch name	<input type="text"/>	Branch code	<input type="text"/>
Account type	<input type="text"/>		

CLAIM PAYMENT DETAILS

I, in my capacity as claimant, hereby certify that the above information submitted by me, is to the best of my belief and knowledge both true and correct. I further confirm that I have not withheld, concealed or misstated any information. I further understand that any misstatement or non-disclosure of information, which materially affects the assessment of this claim, will entitle liberty life to declare this claim null and void.

Claimant's name and surname	<input type="text"/>		
Claimant's signature	<input type="text"/>	Date	<input type="text"/> D <input type="text"/> D - <input type="text"/> M <input type="text"/> M - <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y