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

Postal code

Telephone numbers: Home | Work | Cell | Fax

Email address

DECLARATION:

I, the claimant, do hereby warrant the above information as the truth. I authorise any hospital, clinic, doctor, or other individual to furnish RCS with any information in respect of the claim, including any copies of medical records, consultations, medical history, sickness or injuries the deceased have had with any institution. I have not witheld any information which could be material to the assessment of the claim.

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 of deceased

DNat. June 17

RCS Building, Golf Park 6, Raapenberg Road, Mowbray, 7700
PO Box 111, Goodwood, 7459
Tel: 0861 729 727
Fax: +27 (0)21 597 4733

www.rcs.co.za

RCS
BNP PARIBAS GROUP

MEDICAL REPORT

TO BE COMPLETED BY MEDICAL PRACTITIONER

Surname and names of life insured

ID number of life insured

Date of death

Direct cause of death

Date of first diagnosis (D D M M Y Y Y Y)

Was the deceased informed of diagnosis? Y N

Direct contributing condition/s that resulted in the immediate cause of death

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.)

CONSULTATION 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

MP number

Surname and initials of medical practitioner

Practising Address

DNat.June 17

PRACTICE STAMP

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