

NOTIFICATION OF DEATH OF MEMBER CLAIM FORM
MEDSCHEME LIFE ASSURANCE CO. LTD

DECEASED'S DETAILS	
Policy number	
Benefit	
Name	
ID number	
Medical aid no.	
Date of death	
Place of death	
Cause of death	
Circumstances surrounding Death	
BENEFICIARY'S DETAILS	
Name	
ID number	
Relationship to deceased	
Contact number: (H)	
(B)	
(Cell)	
PAYEE DETAILS	
Account holder	
Name of Bank & Branch name	
Account number	
Account type	
Bank code	
DECLARATION	
I hereby certify that the above information is true and correct in every detail and Medscheme Life is hereby authorised to make payment as stated above. I agree that payment by Electronic Fund Transfer shall be in full and final settlement of Medscheme Life's liability in terms of the Policy.	
Claimant's signature	
Date	

Please register mail the original claim form to FMI, P. O. Box 223, Mt Edgecombe, 4300, together with the original certified supporting documentation. Please refer to our website for the list of document requirements www.fmi.co.za or contact our Client Care Centre 086 010 1119.

PLEASE BE REMINDED THAT YOU HAVE SIX MONTHS FROM THE DATE OF DEATH TO SUBMIT ALL REQUIRED ORIGINAL CERTIFIED DOCUMENTATION. FAILURE TO DO SO WILL RESULT IN REPUDIATION OF YOUR CLAIM.