

The Family Indemnity Plan

CLAIM STATEMENT

Please write in **BLOCK** letters and **WITHIN THE BOXES**, AVOIDING CONTACT WITH THE EDGE OF THE BOX ; mark all choice boxes with an **X** and **NOT** with a tick (✓).

Complete in detail and forward with a **Death Certificate** and a copy of the **Birth Certificate** or **ID Card**.

To be completed by the Organisation.

Organisation			
Telephone Number		Date	
		<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Fax Number		mm dd yyyy	
Member's Name		Certificate Number	
Deceased's Name			
Deceased's Date of Birth		Deceased's Date of Death	
<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> mm dd yyyy		<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> mm dd yyyy	
		Plan	
		<input type="checkbox"/>	
		Plan Amount	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>	
Deceased's Usual Duties of Livelihood (i.e. Fireman, Labourer, etc.)		Relationship To The Member	
Remarks			
Claimant Signature		Print Name	
Authorised Organisation Signature		Print Name	

I hereby certify that the above information is true and correct, **premium has been paid**, and any facts not revealed above are explained in the **REMARKS** section. The Office that administers this Program is hereby released with respect to payments made on behalf of the above insured person.



