

# TRANSPORT SECTOR RETIREMENT FUND



## FUNERAL / DEATH AND DISABILITY CLAIM NOTIFICATION



### TYPE OF CLAIM AND SECTIONS TO BE COMPLETED PER CLAIM TYPE

TYPE OF CLAIM (Mark with "X")	SECTIONS TO COMPLETE IN FULL								CHECKLIST
Funeral / Death Claim	A	B	C	D	E	F	G	H	THIS DOCUMENT HAS TO BE COMPLETED IN FULL. REFER TO SECTION H FOR DOCUMENTS TO ATTACH
Disability Claim	A	B		D	E	F	G	H	

#### A. CURRENT EMPLOYER INFORMATION

Name of Employer							
Employer Address							
Region		Contact Person's Cell No					
Contact Person's Name		Contact Person's Tel. No					
Contact Person's Email Address		Contact Person's Fax No					

#### B. MEMBER DETAILS

Surname of Member																				
First Name of Member																				
Member's Physical Address				Country		Code														
Member's Postal Address				Country		Code														
Employee No				System No																
Gender (Female/Male)				ID/Passport No																
Date of Birth		D	D	M	M	Y	Y	Y	Y	Date Joined Fund		D	D	M	M	Y	Y	Y	Y	
Date of Last Contribution		D	D	M	M	Y	Y	Y	Y	Amount of Contribution		R	0	0	0	0	0	0	0	0

#### C. DECEASED DETAILS

Surname of Deceased				Relationship to Member									
First Name of Deceased													
Date of Birth		D	D	M	M	Y	Y	Y	Y	ID/Passport Number			
Date of Death		D	D	M	M	Y	Y	Y	Y	Marital Status			

#### D. BENEFICIARY / CLAIMANT DETAILS

Name of Beneficiary / Claimant							
Relationship to the Deceased							
Physical Address				Country		Code	
Postal Address				Country		Code	
Cell No				Landline Tel No			
Email address				Fax No			
Alternate Person				Contact No of Alternate Person			

#### E. MEMBER TAXATION INFORMATION

Tax Number of Main Member							
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#### F. BENEFICIARY / CLAIMANT BANK DETAILS

Name of Account Holder		Name of Bank	
Name of Branch		Type of Account	
Account No		Branch Code	

Please note that the Funeral benefit will be paid into the above bank account and authorisation is hereby irrevocably given to the Fund and/or the Fund Service Provider to pay such benefit by Electronic Fund Transfer (EFT). Neither the Fund nor the Fund Service Providers will be held liable for any errors, omissions or incorrect details in the information provided. The onus lies with the Member or Claimant.

#### G. MEMBER / BENEFICIARY / CLAIMANT DECLARATION

I, \_\_\_\_\_ (full name) a member of the Transport Sector Retirement Fund (Fund), beneficiary / claimant hereby confirm the and declare that:  
 All information provided in this Claim Notification together with all supporting documents / information is true and correct. This Claim Notification was completed by me personally, or with the assistance of someone with my approval. I understand the information provided and confirm that same is true and correct. I have not withheld any information that will have relevance to the acceptance / declining of this claim. Should any documents / information be found to be fraudulent, the Fund and / or the Fund Service Providers reserve the right to proceed with the appropriate action against me as the liability to provide accurate and complete information, rests with me. In the event of any loss suffered as a result of any details provided on this notification and supporting documents being inaccurate, incorrect, incomplete or fraudulent, neither the Fund nor the Fund Service Providers will be liable for such loss. I understand that the death and disability benefit may be subject to taxing terms of the applicable tax legislation.

Signature of Member / Beneficiary / Claimant: \_\_\_\_\_ Date Signed: \_\_\_\_\_

H. DOCUMENTS TO ATTACH			
	FUNERAL	DEATH	DISABILITY
CERTIFIED DEATH CERTIFICATE	X	X	
CERTIFIED COPY OF ID FOR:			
MEMBER	X	X	X
SPOUSE	X	X	
BENEFICIARIES / CLAIMANT	X	X	
CERTIFIED COPY OF UNABRIDGED BIRTH CERTIFICATE FOR CHILD(REN)	X	X	
CERTIFIED COPY OF MARRIAGE CERTIFICATE (TRADITIONAL)	X	X	
NOTICE OF DEATH (BI-1663)	X	X	
BANKING DETAILS NOT OLDER THAN THREE MONTHS FOR:			
MEMBER			X
SPOUSE	X	X	
BENEFICIARIES / CLAIMANT	X	X	
CERTIFIED COPY OF AFFIDAVIT FOR:			
MEMBER			
SPOUSE	X	X	
BENEFICIARIES / CLAIMANT	X	X	
WITNESSES	X	X	
COPY OF LATEST PAYSIP	X	X	X
CONFIDENTIAL MEDICAL REPORT BY ATTENDING PHYSICIAN			X
PROOF OF SCHOOLING	X		
CONTRIBUTION HISTORY OF MEMBER	X	X	X
NOMINATION OF BENEFICIARY FORM		X	
EMPLOYER STATEMENT SIGNED AND DATED BY THE EMPLOYER			X
MEMBER STATEMENT SIGNED AND DATED BY THE MEMBER			X
JOB DESCRIPTION			X
MAINTENANCE ORDER/DIVORCE ORDER		X	X
PROOF OF INDEBTEDNESS IN TERMS OF SECTION 19 (5) (a) AND OR 37D OF THE PENSION FUNDS ACT		X	X

**Notes:**  
 In some instances, further documents and /or information may be required to determine the validity of a claim. All documents required in the claim notification must be submitted and failure to do so timeously, may result in claim payments being delayed and / or certain risk benefit claims being declined. Claims are assessed on receipt of complete documentation, including certified documents as indicated above, and failure to do so, will result in the delay of processing the claim.

I. SUBMISSION DETAILS				
Claim Type	Electronic	Fax	Telephone Enquiries	Physical address
Funeral / Death	members@rflipf-sanlam.co.za	011 544 8302	011 544 8300	SALT Employee Benefits (Pty) Ltd, Central Park Office No 400, 16th Road
Disability	members@rflipf-sanlam.co.za	011 544 8302	011 544 8300	Randjespark Office Block Q, Midrand

J. EMPLOYER DECLARATION	
EMPLOYER STAMP	<p>Declaration by employer (authorised personnel only):            I, _____ (full name) in the capacity of,            _____ (designation), hereby certify that all information provided in this Claim Notification and supporting documents are true and correct to the best of my knowledge and belief. I confirm that the options in terms of the Rules of the Fund have been fully explained to the member / beneficiaries / claimant and that the member / beneficiaries / claimant is aware of the content of the claim notification and any liabilities that he/she may have. In the event of any loss suffered as a result of any details provided on this notification and supporting documents being inaccurate or incorrect, neither the Fund nor the Fund Service Providers can be held liable for such losses.</p>
Signature of Authority _____ Date Signed: _____	

SALT Employee Benefits (Pty) Ltd, an authorised Financial Services Provider in terms of the Financial Advisory and Intermediary Services Act 37, of 2002 ("FAIS Act") with FSP Number 18929 is the appointed administrator to Transport Sector Retirement Fund. SALT Employee Benefits is committed to compliance with the requirements prescribed in the FAIS Act. All disclosures are available on request. The funeral scheme is underwritten by 3Sixty Life Ltd with FSP Number 15107.