

LOSS OF INCOME CLAIM FORM

ACCOUNT HOLDER INFORMATION

Surname	<input type="text"/>
First name	<input type="text"/>
ID number of insured	<input type="text"/>
Card account number(s)	<input type="text"/>
Personal Loan account number(s)	<input type="text"/>

CLAIMANT INFORMATION

Name of claimant	<input type="text"/>											
ID number	<input type="text"/>											
Postal address	<input type="text"/>											
	<input type="text"/>											
	<input type="text"/>											
	<input type="text"/>											
Telephone numbers	Home	Work				Cell	Fax					
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>											

DECLARATION:

I certify that all information provided relative to this claim is true and correct

Yes No

D	D	M	M	Y	Y	Y	Y
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Date

IMPORTANT: DOCUMENTS REQUIRED TO BE ATTACHED TO THIS CLAIM FORM

Certified letter from employer on company letterhead	Yes	No
Certified ID of insured	Yes	No
UI 19 Form (obtained from employer)	Yes	No
Loss of income declaration (pg2)	Yes	No
Affadavit (if requested)	Yes	No
Bank statements (if requested)	Yes	No

Loss of income 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

LOSS OF INCOME DECLARATION

TO BE COMPLETED BY CLAIMANT

DETAILS OF EMPLOYER

Name of employer	<input style="width: 100%;" type="text"/>								
Postal address of employer	<input style="width: 100%;" type="text"/>								
	<input style="width: 100%;" type="text"/>								
	<input style="width: 100%;" type="text"/>								
Contact details of employer	<input style="width: 100%;" type="text"/>								
	<input style="width: 100%;" type="text"/>								
Employee payroll number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
What date were you first made aware of your loss of income?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date employed by employer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
What was the date you last attended work?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
What was your occupation immediately before loss of income?	<input style="width: 100%;" type="text"/>								
Reason for loss of income?	<input style="width: 100%;" type="text"/>								
	Staff reduction	<input type="text"/>	<input type="text"/>						
	Voluntary retrenchment	<input type="text"/>	<input type="text"/>						
	Medical boarding	<input type="text"/>	<input type="text"/>						
	Resignation	<input type="text"/>	<input type="text"/>						
	End of fixed term contract	<input type="text"/>	<input type="text"/>						
	Other	<input type="text"/>	<input type="text"/>						
If other please specify	<input style="width: 100%;" type="text"/>								
Have you received any verbal or written reprimand which constituted part of your employer's disciplinary procedure in the six months prior to termination of employment?	<input type="text"/>	<input type="text"/>							

INDUSTRIAL COURT ACTION

Is any industrial court action pending?	<input type="text"/>	<input type="text"/>
PLEASE NOTE: Guardrisk reserves the right to reclaim the benefit paid if you are reinstated and your company reimburses you for lost income.		

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