



FURNITURE BARGAINING COUNCIL

Suite 1 & 2 ♦ Reitz Park ♦ 80 President Reitz Avenue ♦ Westdene ♦ Bloemfontein ♦ 9301
Correspondence to be addressed to: THE PROVINCIAL MANAGER ♦ Post Office Box 3914 ♦ Bloemfontein ♦ 9300
Telephone (051) 447-1807 ♦ Facsimile (051) 447-2554 ♦ e-mail freestate@furnbed.co.za ♦ Website www.furnbed.co.za

FURNITURE BARGAINING COUNCIL DEATH AND DISABILITY SCHEME

DEATH BENEFITS CLAIM

Claim Number

Claim Date

DECEASED MEMBER'S DETAILS

Deceased Member's First Name/s :

Deceased Member's Surname :

Deceased Member's Identity Number :

Deceased Member's Industry Number :

Deceased Member's Last Employer in Industry :

Deceased Member's Date of Birth

Deceased Member's Date of Death

Death Certificate Number : Dated:

Benefit Entitlement :

FIRST CLAIMANT'S DETAILS

Claimant's First Name/s :

Claimant's Surname :

Claimant's Identity Number :

Claimant's Relationship to Deceased Member :

Claimant's Marriage Certificate Number (if applicable): Dated:

Claimant's Physical Address: : Postal Code:

Claimant's Postal Address: : Postal Code:

Claimant's Telephone Number/s :

SECOND CLAIMANT'S DETAILS

Claimant's First Name/s :

Claimant's Surname :

Claimant's Identity Number :

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Claimant's Relationship to Deceased Member :

Claimant's Marriage Certificate Number (if applicable): Dated:

Claimant's Physical Address: :

Postal Code:

Claimant's Postal Address: :

Postal Code:

Claimant's Telephone Number/s :

THIRD CLAIMANT'S DETAILS

Claimant's First Name/s :

Claimant's Surname :

Claimant's Identity Number :

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Claimant's Relationship to Deceased Member :

Claimant's Marriage Certificate Number (if applicable): Dated:

Claimant's Physical Address: :

Postal Code:

Claimant's Postal Address: :

Postal Code:

Claimant's Telephone Number/s :

DEATH BENEFIT PAYMENT DETAILS

I, Mr/Ms (Print First Name/s and Surname) recommend the payment of Death Benefits to the following beneficiaries:

Beneficiaries full first name/s and surname	R	Benefit amount paid	Cheque number/s	Cheque date/s															
				Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
	R			Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
	R			Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
	R			Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
	R			Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
	R			Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D
Total Paid	R																		

I, the undersigned Mr/Ms (Print First Name/s and Surname) have fully investigated the validity of this Death Benefits claim and I authorise the above recommended distribution of Death benefits.

SIGNED:

DATE: