

CLIENT SERVICES UNIT DEATH CLAIM FORM

Principal Membership Number				Date:			
Deceased Membership Number							
Principal Member's Name:							
Telephone Number:			Email Address:				
TYPE OF CLAIM							
Claim on principal member Claim on nominated member							
DETAILS OF DI	ECEASED	MEMBER					
Package Type:	Brass	Brass Plus	Bronze	Silver	Gold	Diamond	Platinum
Surname:							
Middle name:							
First Name:							
Date of Birth:	Date of Birth: Date of Death:						
Relationship:							
ID Type:	Voter ID	Driver's	License	Passport	: N	National ID	NHIS
ID Number:							
Place of Death:	Home	Hospital	Other	Plea	se Specif	fy	
Body Deposited in Mortuary/Funeral Home: Yes No							
Name and Contact details of Mortuary/Funeral Home							
Date/Intended Date of Burial (DD/MM/YYYY)							
(The Trust requires a minimum of 6 weeks between the time of reporting and date of funeral; with no funeral events organized by the Trust in December & January)							
Name of Church/ Mosque to handle the burial							
DOCUMENTS A	ATTACHE	D					

3. Death Certificate

4. Medical Cause of Death Certificate; affixed with the stamp of the specific doctor (general hospital stamps

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2. ID of Deceased

1. ID of Claimant

DO NOT suffice)

DETAILS OF C	LAIMANT						
Name of Claimar	nt						
Telephone No	Email Address:						
Date of Birth:							
Relationship							
Postal Address							
ID Type:	Voter ID	Driver's License	Passport	National ID	NHIS		
ID Number:							
LOCATION OF	DECEASED						
Town	n District			Region			
LOCATION OF	BURIAL & F	UNERAL SERFVICE	S				
Town		District		Region			
Specify any Land	mark						
I further declare that the above statements and answers to the above questions are full and true, that I have withheld no material information and that I undertake to furnish any documentation which may be required by FAMILYCARE.							

answers to the above questions are full and true, that I have withheld no material information and that I undertake to furnish any documentation which may be required by FAMILYCARE.

I expressly waive all provisions of law, customs or professional etiquette forbidden any physical or other person who attended or examined the deceased, or any institution in which the deceased received treatment, to disclose any knowledge or information which was there by acquired and I authorize all such persons or agencies to furnish any information in their possession to FAMILYCARE.

Signature of Client

NB: The Trust maintains the right to decline benefits for claims which are found not to have been compliant with the terms and conditions.

OFFICE USE ONLY

Comments



CLIENT SERVICES UNIT PAYMENT INFORMATION FORM

Principal Membership Number				Date:		
Principal Member	's Name:					
Telephone Numbe	r:					
PAYMENT OPTI	ON (please	select only one prefer	red payment o	ption)		
Cash Benefit Amo	unt GH	¢				
Bank Transfer						
Name of Bank						
Account Name						
Account Number						
Branch Name						
Cheque Payment						
Name of Payee						
Mobile Money (N	ITN Numbe	rs only)				
Mobile Money Nu	mber:					
Name on Mobile M	Money Wallet	:				
MTN Mobile Mor	ney payments	s have a threshold of no	ot more than G	HS2,000.00		
ID Type:	Voter ID	Driver's License	Passport	National ID	NHIS	
ID Number:						
OFFICE USE ON	ILY					
Relationship Offic	er		Brancl	h		
Handled By			Designation			
Signature			Date			
Approved By			Design	nation		
Signature			Date			