

## Claim Form



1.	Main Member Details:  Name & Surname:  ID Number:  Postal Address:  Physical Address:  Marital Status: Married Single Divorced  Date of Marriage/Divorce:	2.	Telephone Number: (Home)  Telephone Number: (Work)  Cellphone Number:  Fax Number:  Email:
3.	Membership Number:		
4.	Details of Claimant:  Name & Surname:  ID Number:  Contact Details:  Claimant listed on policy: Yes No		
5.	Nature of Claim:  Legal   Dread Disease   Hospitalisation   Income Protector		Policy Type:  Legal Shield  Medi Shield  Salary Shield  Next Generation Legal Shield
6.	CR/Summons/Case Number: Any other reference Number:		
7.	Date when the incident which gives rise to this claim occured:		
8.	Banking details: (for hospital, dread disease and income protector payouts) Account Holder Name: Bank Name: Account Number: Branch Code/Name: Type of Account:		
9.	Details of previous claim/s submitted with Trustco Insurance Ltd/Trustco Life Ltd:		

11.	A detailed statement concerning your claim:
12.	Preferred legal action to be taken (if applicable):
13.	Documents attached:
A)	
	by, certify that the above information is to the best of my knowledge true and correct and fully understand that this claim may udiated in the event that I have intentionally provided Trustco Insurance with false information.
Signatı	ure of Person Submitting Claim:
	nship to Policy Holder:
Date:	



Rundu Ongwediva





Windhoek