

Claim Form



I.	Main Member Details: Name & Surname:	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		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. A)	Documents attached:
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	, certify that the above information is to the best of my knowledge true and correct and fully understand that this claim may liated in the event that I have intentionally provided Trustco Insurance with false information.
	e of Person Submitting Claim:ship to Policy Holder:





(+264) 61 270 9640 (+264) 66 251 900 (+264) 66 255 066

