

Bryte Life Company Limited
A Fairfax Company

Part One: Employer's declaration			
Important information			
1. This form is to be completed by the employer.			
2. Full and accurate answers are to be elicited and recorded.			
General particulars of the employer			
Fund name			
Company name			
Physical address			Code
Contact person			
Telephone number		Email address	
Name of person submitting initial claim advice			
Designation			
General particulars of the member/claimant			
Surname		First name	
Date of birth		ID number	
Telephone number			
Employer's name		Division	
Occupation		Employer's reference number	
Date on which the member/claimant	a. Joined the company		
	b. Joined the fund/scheme		
Last day actively at work		Date of disability	
Cause of disability (if known)			
Please include a copy of the member's last payslip.			
Details of employment			
What is the member's current position? (Full details to be provided in sections 5 and 6 of this form)			
Is the member still working		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date appointed as a full-time employee			
Salary prior to the date of disability			
Is the member still receiving a salary?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Current salary amount			
Effective date			
When do you intend to cease this salary?			
When do you expect the member to resume work?		<input type="checkbox"/> Part-time	<input type="checkbox"/> Full time
If the member has returned to work, please specify in what capacity	<input type="checkbox"/> Same job		
	<input type="checkbox"/> Adapted job		
	<input type="checkbox"/> Alternative job		

Details of disability

Please provide details about the member's disability/incapacity to the best of your ability or knowledge.

What do you understand is wrong with your employee	
State the date of the first indication of disability	
State the nature of the first indication of disability	
How does the disability affect the member's ability to perform their duties?	

Complete the member's sick leave record for the last 2 years

From	To	Number of working days	Reason

Payee Details

Account holder		Name of bank	
Account number		Branch code	
Account type		Reference	

Note: Please provide proof of the bank account by submitting one of the following:

- A letter from the bank confirming the account details (not older than three months).
- A bank statement (not older than three months).

Payment will only be made via electronic fund transfer.
Benefit payments will be made directly to the policyholder or the nominated beneficiary.
Valid claims will be paid within 48 hours of receipt of all documentation. As Bryte Life banks with FNB, payments to other banks may take up to 72 hours to reflect.

Declaration

I, _____, identity number _____, declare that the statements and information provided above are true and complete. In the event that this claim or any supporting documentation is found to be fraudulent, Bryte reserves the right to proceed with the appropriate action against me/claimant. By signing this document I/claimant confirm that I have a legal right and entitlement to claim the relevant benefits.

Signature _____ Signed at _____

on this _____ day of _____ 20_____

Personal Information

We respect your constitutional right to privacy and are committed to and bound by the terms and provisions of the Protection of Personal Information Act 4 of 2013 ("POPI") regarding the acquisition, usage, retention, transmission, and deletion of your personal information. We will check and validate the information you provide through legal means. We have high-level security measures in place to protect your personal information. The information herein collected is for the primary purpose of providing you with insurance cover and for all other activities and processes incidental to and relevant to this purpose. The information shall be kept confidential; however, we shall disclose it to certain third parties as required and other insurers for the specific purpose of insurance to reduce and prevent any form of fraudulent activity. Sharing of information includes, but is not limited to, information sharing as arranged via the South African Insurance Association.

You hereby give consent and fully understand the reason for Bryte to process, use, share and retain the personal information for its designated purpose and you confirm the accuracy of the information. You may request Bryte to amend, update, change or correct the personal information processed by us by sending a request to your broker or your nearest Bryte office. You further consent to Bryte retaining the information in line with the legally permitted retention period for statistical and reporting purposes only.

I _____ (main member name and surname) confirm that I have the consent to share the personal information provided herein. A full version of our Privacy Statement is available for download at this link https://www.brytesa.com/pdf/Bryte_Africa_Group_Privacy_statement_1866.pdf

Claim Requirements								
Documentation	Member	Spouse	Parent	Child	Stillborn	Extended Family	Grocery Benefit	Baby Birth Benefit
Fully completed and signed claim form	X	X	X	X	X	X		X
Certified copy of death certificate	X	X	X	X	X	X		
Certified copy of DHA-1663A (Notification of Death & Burial Order DHA-14A)	X	X	X	X	X	X		
Certified copy of the main member's identity document	X	X	X	X	X	X		X
Certified copy of identity document/birth certificate of the deceased	X	X	X	X	X	X		
Beneficiary Nomination Form*	X	X	X	X	X	X		
*If No Beneficiary Nomination form: Letter of Authority/Appointed Beneficiary by the High Court, alternatively: <ul style="list-style-type: none"> • Certified copy of the High Court appointment of the Executor • Contact details of Executor • Proof of Estate Late account details (not older than three months) 	X	X	X	X	X	X		
A certified copy of the Nominated/Appointed Beneficiary's ID document	X	X	X	X	X	X		
Proof of payee banking details (not older than three months)	X	X	X	X	X	X		X
Copy of police report (if the cause of death is unnatural)	X	X	X	X	X	X		
Proof of cover/funeral cover application form (if applicable)	X	X	X	X	X	X		X
Fund Beneficiary nomination form (if available)	X	X	X	X	X	X		
Three months' payslips/proof of contributions (if applicable)	X	X	X	X	X	X		X
Proof of relationship The following will be deemed acceptable proof of marriage: <ul style="list-style-type: none"> • Marriage Certificate • Copy of Lobola letter • Letter from the District Councilor confirming union, • Fund Beneficiary nomination form. • Medical Aid Certificate • Any document confirming financial dependency. • Nomination Form* 		X		X	X	X		X
Proof of relationship for parent or parent-in-law <ul style="list-style-type: none"> • Affidavit from a 3rd party • Nomination Form* 			X				X	
If over the age of 21 years, proof of full-time schooling from a recognised educational institution				X			X	
Proof of disability, if over the age of 21 years				X			X	

Documentation	Member	Spouse	Parent	Child	Stillborn	Extended Family	Grocery Benefit	Baby Birth Benefit
Proof of parenthood/guardianship <ul style="list-style-type: none"> • Unabridged birth certificate • Letter of Guardianship from Court • Nomination Form* • Road to health chart • Beneficiary Nomination Form • Medical Aid Certificate • Hospital records detailing names of parents. • Any documents confirming financial dependency. 				X	X		X	X
Stillborn <ul style="list-style-type: none"> • Medical report stating pregnancy term in weeks 					X		X	

We reserve the right to request any further information at claim stage to accurately assess and validate the claim.