

**CLAIM FORM – RETRENCHMENT BENEFIT**

CLF 8

TO BE COMPLETED BY THE INSURED

Policy No.

Surname

Date of Birth

First Names

Postal Address

Code

DETAILS OF EMPLOYER

Name of employer

Main activity of employer

Postal Address

Code

Number of employee

Tel

Date employed by employer

What was the date you last attended work

What was your occupation immediately before retrenchment?

Reason for retrenchment

Had you received any verbal or written reprimands which contributed part of your employer's disciplinary procedure in the last six months prior to termination of employment?

AUTOPAGE CONTRACT DETAILS

Account Number  Branch Code

Commencement date of retrenchment insurance

Monthly installment  Principle debt

INDUSTRIAL COURT ACTION

Is any industrial court action pending?

Please note: If any industrial court action is pending we will pay your claim. However, if you are reinstated and your company reimburses you for the lost income, we will reclaim the benefits paid. Please advise us of the outcome of such action.

OTHER REQUIREMENTS

- To enable the Insurer to process this claim the following documentation must be attached.
1. Letter from your employer stating the reason for you suffering a job loss including the date on which your retrenchment became effective including a "certificate of employment"
  2. Certified copy of your Identity Document
  3. Any other information the insurer may require.
  4. Unemployment Card or Certificate

DECLARATION

Hereby declare and warrant that the answers given above are to be the best of my knowledge, and I believe them to be factual, true and correct, whether in my handwriting or not, and that no information has been withheld nor relevant circumstances omitted. I understand that Capital Alliance may contact my employer for any additional information that they might require.

Signed at (place)  Date Signed

Signature (insured)