



MOTOR INDUSTRY FUND ADMINISTRATORS
APPLICATION FOR DEATH CLAIM

Guide to the completion of the application for Death benefits.

PART 1 (Pages 1, 2 and 3)

To be completed by the deceased's Employer.

Part 2 (Pages 4, 5, 6, 7, 8, 9 & 9i)

All claimants are to complete D/B 1 (Pages 9 and 9i), Annexure 'A' (Page 4) and Banking details (Page 8)

Please refer to notes here below

NOTES:

- 1** Widows (legal and customary law) who are able to submit certified proof of the marriage must complete -
D/B 1 - Pages 9 and 9i
Annexure 'A' - page 4

- 2** Common law and customary law widows who can not supply certificates of marriage must complete -
D/B 1 - Pages 9 and 9i
Annexure 'A' - page 4
Annexure 'B' - Page 5
Annexure 'C' - Page 6
Banking details - Page 8

- 3** Ex-spouses, partners as well as Guardians, who are not biological parents, of the deceased's minor child / children must complete -
D/B 1 - Pages 9 and 9i
Annexure 'A' - page 4
Annexure 'D' - Page 7

CERTIFICATE OF SERVICE - to be completed by the EMPLOYER

COMPANY NAME _____

This is to certify that the particulars mentioned hereunder are true records of the employment by the company of

Employee Council number

Employee Surname

Employee Full names

Identity Number

Period employed From To
D D M M Y Y Y Y D D M M Y Y Y Y

If applicable - dates member was absent from work immediately prior to death

Reason for absence: _____

From To
D D M M Y Y Y Y D D M M Y Y Y Y

Employee's termination Weekly / Monthly / Annual earnings were R _____

Reason for termination of employment - **mark with an X**

- Retirement - 55 years and older
- Retrenchment
- Death
- Other - please state: _____
- Resignation / Dismissal
- Disability

Termination date to be reflected on the Monthly Returns to Mibco
D D M M Y Y Y Y

It is hereby acknowledge that the Employer will be held liable for any loss by the Fund in the consequence of a false declaration of retrenchment/ Redundancy.

SIGNED FOR AND ON BEHALF OF THE EMPLOYER

DATE

INITIALS AND SURNAME

DESIGNATION

Contact number

COMPANY STAMP

PENSION AND PROVIDENT FUNDS

Member's Council number: [] [] [] [] [] [] [] [] [] []

To be completed by the member's employer in all cases where a Form A is applicable, and submitted by the Trustee / Administrator / Insurer of the Fund in conjunction with a Form A to SARS.

Name of Employer _____

Employer's Address _____

_____ Code _____

1 Employee's Surname _____

Employee's First name _____

2 Highest average salary actually earned by the taxpayer during any five consecutive years in the service of the employer during his membership to the fund.

YEAR			

SALARY							
R							
R							
R							
R							
R							
R							
R							
R							

TOTAL R [] [] [] [] [] [] [] []

Average for 5 years or lesser period if employee was employed for a lesser period R [] [] [] [] [] [] [] []

3 To be completed on the death of an employee - twice the salary during 12 months immediately preceding death R [] [] [] [] [] [] [] []

Note: For the purpose of question 2 and 3, 'Salary' includes any amount received or receivable annually under a contract of service as also cost of living allowances, commission, share of profits, etc, but not occasional bonuses or fees which were dependant on the whim of the Directors or employer.

DECLARATION

Certified correct to the best of my knowledge and belief.

MANAGER / SECRETARY

[] [] [] [] [] [] [] []
D D M M Y Y Y Y

ANNEXURE 'A'

DECEASED'S FULL NAME: _____

DECEASED'S COUNCIL NR:

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In terms of Section 37© of the Pension Fund's act, the following additional information is needed to assist in determining dependants and the distribution of the benefits:

1 Was the deceased previously married? **YES** **NO**
If **YES**, please supply the name, address and contact nr of the ex-spouse/s and a copy/copies of either the Divorce Order/s or the ex-wife's Death Certificate/s if applicable.

2 If deceased was divorced did he/she remarry after his/her divorce? **YES** **NO**
If **YES**, please supply the spouses' name, address and contact nr.

3 Did the deceased enter into Customary Union? **YES** **NO**
If **YES**, supply names, addresses and contact details.

4 Were any children born out of wedlock? **YES** **NO**
If **YES**, supply details of the children's names, addresses and birth certificate.

4.1 Name, address and contact nr of children's guardians and guardian's relationship to deceased:

5 Was the deceased required to pay any child maintenance? **YES** **NO**
If **YES**, please supply a certified copy of the Maintenance / Divorce Order.

6 Are any of the deceased's minor children being cared for by someone other than their mother?
YES **NO**
If **YES**, please arrange for guardian to complete annexure 'D' where necessary and provide details of their names, addresses and contact nr. _____

7 If member died as a result of illness / injury and was unemployed at date of death, please supply copies of all medical certificates on hand.

SIGNATURE OF APPLICANT

DATE

PLEASE NOTE:

**All affidavits to be signed by a Commissioner of Oaths & bear his rubber stamp
No alterations or tippex on any of the documents will be permitted**

ANNEXURE 'B'

AFFIDAVIT - BY CUSTOMARY UNION / COMMON LAW WIFE

(To be completed if Customary Union Certificate unavailable or a common-law relationship existed)

DECEASED'S FULL NAME: _____

DECEASED'S COUNCIL NR:

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I the undersigned,

Name _____

ID No.

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Address: _____

Tel No:

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Cell No:

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state under oath that I was living with the deceased: - Name _____

_____ and ID No.

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as man and wife from

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 to

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Number of children born from this Union: _____

NAME	AGE	DATE OF BIRTH

Did the deceased have any other relationships? YES NO

If YES, state names, addresses and contact nr of such persons: _____

Were any other children born out of the above-named relationships? YES NO

If YES, state names, addresses and contact nr: _____

Are you aware of any other dependants? YES NO

If YES, state names, addresses contact nr and relationship to deceased: _____

I know and understand the contents of this affidavit, that the facts herein are to the best of my knowledge true and correct and I have no objection in taking the prescribed oath which I consider to be binding on my conscience.

Signature of Deponent

Signed and sworn before me at (PLACE) _____ on this _____ day of

MONTH _____ YEAR _____ by the deponent who has acknowledged the fact that he/she knows and understands the contents of this affidavit.

Commissioner of Oaths

Commissioner's stamp

PLEASE NOTE: This affidavit must be supported by completed Annexure 'C'

BENEFICIARY'S BANKING DETAILS

Banking details **MUST BE SUPPLIED** on a printed bank form.

Member's Council Number

Account Holder Name

Name of Bank

Branch Code

Account Number

Type of Account Savings Cheque Transmission
 Other _____

Account Holder Signature

Full Names and Surname of Bank Official

Bank Official Signature

BANK STAMP

BENEFICIARY DECLARATION AND SIGNATURE

I, the undersigned, hereby certify that the given information is correct in all aspects. I hereby authorize the Fund to deduct from any benefits due to me, an amount which equates to the prescribed Moto Health care contributions in respect of the period during which I received benefits from motto Health care, subsequent to the termination of my employment in the motor industry, and the consequential termination of the membership of Moto health Care.

BENEFICIARY'S SIGNATURE

D D M M Y Y Y Y

****PLEASE NOTE THE FOLLOWING DOCUMENTATION MUST BE SUBMITTED WITH THIS APPLICATION**

A certified copy of the late member's Identity book
Death certificate
Marriage Certificate / Sworn Statement
DB1 for each Claimant
Birth Certificate's of All minor children
Beneficiary form
Completed Certificate of Service - by the EMPLOYER (See Pg. 3)

Medical reports - if applicable
Form A&D - to be completed by EMPLOYER
If Divorced, copy of the divorce order
ID's for all claimants
Sworn Statements
Affidavit - Who cares for minor children

COMPLETED APPLICATION WITH ALL SUPPORTING DOCUMENTATION MUST BE SENT TO YOUR LOCAL MIBCO OFFICE

REGION	CONTACT NUMBER
MIBCO Eastern Cape PO BOX 7270 PORT ELIZABETH - 6055	(041) 364-0250
MIBCO Natal PO BOX 17263 CONGELLA - 4013	(031) 205-5465
MIBCO Free State OFS PO BOX 910 BLOEMFONTEIN - 9300	(051) 409-4000

REGION	CONTACT NUMBER
MIBCO - HIGHVELD P O BOX 2578 RANDBURG - 2125	(011) 369-7500
MIBCO NORTHERN REGION P O BOX 2578 RANDBURG - 2125	(011) 369-7500
MIBCO WESTERN CAPE P O BOX 17 BELLVILLE - 7535	(021) 948-6400/05

