



## THE CONTRACT CLEANING NATIONAL PROVIDENT FUND

### FORM A: FUNERAL, DEATH AND DISABILITY CLAIM FORM



Please complete both pages of Form A as well as Form B (if applicable) and submit with all attachments to SA Quantum.

TYPE OF CLAIM AND SECTIONS TO BE COMPLETED PER CLAIM TYPE													
Claim Type (Mark with "X")	Sections to Complete	Claim Type (Mark with "X")	Sections to Complete										
Funeral Claim - Dependant	A, B, C, D, G, H, I, J	Death Claim	A, B, C, D, E, F, G, H, I, J										
Funeral Claim - Member	A, B, C, D, G, H, I, J, Form B	Disability Claim	A, B, D, E, F, G, H, I, J,										

A. EMPLOYER DETAILS													
Name of Employer													
Employer Address													
Region						Contact Person's Name							
Contact Person's Cell.						Contact Person's Tel. No.							
Contact Person's Email						Contact Person's Fax No.							

B. MEMBER DETAILS																						
Surname of Member																						
First Name of Member																						
Member's Physical Address																						
						Country				Code												
Member's Postal Address																						
						Country				Code												
Member's Category						Gender (Female/Male)																
Employee No.						Fund Reference No.																
Date of Birth		D	D	M	M	M	Y	Y	Y	Y	ID/Passport No.											
Date of Last Contribution		D	D	M	M	M	Y	Y	Y	Y	Amount of Contribution		R									
Date of Employment		D	D	M	M	M	Y	Y	Y	Y	Date Joined Fund		D	D	M	M	M	Y	Y	Y	Y	
Basic Salary per Hour		Rate				No. of Hrs.				Basic Salary as at Date of Incident		R										

C. DECEASED DETAILS														
Relation to Member														
Surname of Deceased														
First Name of Deceased														
Date of Birth		D	D	M	M	M	Y	Y	Y	Y	ID/Passport Number			
Date of Death		D	D	M	M	M	Y	Y	Y	Y	Marital Status			

D. CLAIMANT DETAILS													
Name of Claimant													
Relation to Deceased													
Physical Address													
						Country				Code			
Postal Address													
						Country				Code			
Cell No.						Landline Tel. No.							
Email						Fax No.							
Alternate Person						Contact No. of Alternate Person							

E. ALLOWABLE DEDUCTIONS																				
Court Orders		Is there a Divorce Order in respect of the Member?				Yes	No	Is there a Maintenance Order against the Member?				Yes	No							
Indebtedness to the Employer (Sect 37D of PFA)		Is the Member indebted to the Employer?				Yes	No	Amount Owing		R										



**F. MEMBER TAXATION INFORMATION**

Tax Office		Tax No.	
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**G. BANKING DETAILS FOR CLAIM BENEFIT PAYMENT**

Name of Account Holder		Name of Bank	
Name of Branch		Type of Account	
Account Number		Branch Number	

Please note that the benefit will be paid into the above bank account and authorisation is hereby irrevocably given to the Fund and/or the Fund Service Providers to pay such benefit by Electronic Fund Transfer (EFT). Neither the Fund Service Providers nor the Fund will be held liable for any errors, omissions or incorrect details in the information provided. The onus lies with the Member or Claimant.

**H. DOCUMENTS TO BE ATTACHED (Mark with "X")**

Funeral of Child	Certified Copies of: Death Certificate (Bi-5), Child's ID/Passport, Claimant's ID/Passport, Proof of Banking Details stamped by bank - no older than 3 Months, Proof of Parenthood, Proof of Stillbirth (DHA 1663), Proof of Studying (22yrs to 26yrs), Proof of mental or physical disability (if applicable), Copy of Last Salary advice	
Funeral of Spouse	Certified Copies of: Death Certificate (Bi-5), Spouse ID/Passport, Claimant's ID/Passport, Marriage Certificate. Proof of Banking Details stamped by bank - no older than 3 Months, Affidavit from family member or Chief if no Marriage Certificate-proof of relation to be included. Last Salary advice.	
Funeral of Member	Certified Copies of: Death Certificate (Bi-5), Member's ID/Passport, Claimant's ID/Passport. Proof of Banking Details stamped by bank - no older than 3 Months, Proof of claimant relationship. Last Salary advice.	
Death and Fund Credit of Member	Certified Copies of: ID/Passport of Member, Death Certificate, Copy of Member's Payslip, Last 12 months Contribution History of Member, Proof of Banking Details, Proof of Marriage, ID/Passport of Beneficiaries Where Applicable- Maintenance Order, Divorce Order, Proof of Indebtedness	
Disability and Fund Credit of Member	Certified Copies of: ID/Passport of Member, Copy of Member's Payslip, Last 12 months Contribution History of Member, Proof of Banking Details, Employer Declaration, Member Declaration, Job Description, Confidential Medical Report Where Applicable- Maintenance Order, Divorce Order, Proof of Indebtedness	

**Notes:**  
 In some instances, further documents and/or information may be required to determine the validity of a claim.  
 All documents required in this Claim Form must be submitted and failure to do so timeously may result in certain risk benefit claims being repudiated.  
 Death and Disability Claims are assessed on receipt of electronic claim packs but will be finalised upon receipt of original documents.  
 Please note that certain benefits, such as the fund credit where applicable, will only be disinvested on receipt of a properly completed Claim Form and all information/documentation required. This may result in a difference between the benefit as at the termination date and the disinvestment date.

**Submission Details:**

Type of Claim	Electronic	Fax	Telephonic Queries	Postal Address
Funeral of Dependants	ccnpfrisk@saquantum.co.za	086 644 4841	010 003 6500	SA Quantum, Risk Administration Manager, Death Claim, PO Box 781687, Sandton; 2146
Funeral and Death of Member	ccnpfrisk@saquantum.co.za	086 644 4841	010 003 6500	SA Quantum, Risk Administration Manager, Death Claim, PO Box 781687, Sandton; 2146
Disability of Member	ccnpfhrs@saquantum.co.za	086 679 1474	010 003 6500	SA Quantum, Health Risk Services, Disability Claim, PO Box 781687, Sandton; 2146

**I. CLAIMANT DECLARATION (APPLICABLE TO FORM A AND FORM B)**

I, \_\_\_\_\_ (full name) the claimant declares that:

All information provided in this Claim Form together with all supporting documents/information are true and correct;  
 This Form and Form B (where applicable) was completed by me, duly authorised, or with the assistance of someone with my approval;  
 I understand the information/documents provided and confirm that same is true and correct;  
 I have not withheld any information that will have relevance to the acceptance/declining of this claim;  
 Should any documents/information be found to be fraudulent, the Fund Service Providers and/or Fund reserve the right to proceed with the appropriate action against me;  
 In the event of any loss suffered as a result of any details provided on this form and supporting documents being inaccurate or incorrect, neither the Fund nor the Fund Service Providers can be liable for such losses;  
 I authorise any medial attendant or any other person who has attended to the dependant/member or any hospital or other institution which has information about the dependant/member, to disclose this information to the Fund Service Providers. This information will be used to finalise the Claim. I further authorise the Fund Service Providers to provide statistical information when necessary; and  
 I understand that the death and disability benefit may be subject to tax depending on the applicable tax legislation.

Signature of Claimant \_\_\_\_\_ Date Signed \_\_\_\_\_

**J. EMPLOYER DECLARATION (APPLICABLE TO FORM A AND FORM B)**

**EMPLOYER STAMP**

I, \_\_\_\_\_ (full name) in the capacity of \_\_\_\_\_ (designation)

declare that the above information is true and correct to the best of my knowledge and belief. I confirm that the member or claimant is aware of the content of this claim form. In the event of any loss suffered as a result of any details provided on this form and supporting documents being inaccurate or incorrect, neither the Fund nor the Fund Service Providers can be liable for such losses.

Signature of Authority \_\_\_\_\_ Date Signed \_\_\_\_\_

**K. IMPORTANT NOTE**

The Fund's Benefits are administered by the following Service Providers:  
**Funeral, Death and Disability** - Southern Africa Quantum Consultants and Actuaries (Pty) Ltd, an authorised Financial Services Provider in terms of the Financial Advisory and Intermediary Act 37, of 2002 ("FAIS Act") with FSP Number 2001.  
**Fund Credit** - (payable in addition to the Death & Disability above)- NBC Holdings (Pty) Ltd, an authorised Financial Services Provider in terms of the FAIS Act with FSP Number 991.  
 The Service Providers are committed to compliance with the requirements prescribed in the FAIS Act. All Disclosures are available on request.





# THE CONTRACT CLEANING NATIONAL PROVIDENT FUND

## FORM B: FUNERAL - REPATRIATION AND TOMBSTONE

*Benefit is Applicable for Member Funeral Only*



To be completed and submitted together with Form A and all attachments to SA Quantum

TYPE OF CLAIM AND SECTIONS TO BE COMPLETED PER CLAIM TYPE			
Claim Type (Mark with "X")	Sections to Complete	Claim Type (Mark with "X")	Sections to Complete
Repatriation	A, B, D, E	Tombstone	A, C, D, E





### A. MEMBER DETAILS

Surname of Member			
First Name of Member			
Employee No.		Fund Reference No.	
Date of Death	D D M M M Y Y Y Y	Date of Birth	D D M M M Y Y Y Y

### B. REPATRIATION - ONLY APPLICABLE IF PLACE OF DEATH AND PLACE OF RESIDENCE IS OVER 100KM APART

Expected Date of Arrival of Mortal Remains	D D M M M Y Y Y Y	Expected Time of Arrival of Mortal Remains	
Physical Address of Location of Mortal Remains			Country
			Code
Physical Address of Place of Burial of Mortal Remains			Country
			Code
Name of Claimant			Cell Number of Claimant
Landline of Claimant			Alternate Contact Number

### C. TOMBSTONE - CHOOSE ONE TOMBSTONE FROM THE SAMPLES BELOW

 <b>TS 1001</b> Please Tick <input type="checkbox"/>	 <b>TS 1002</b> Please Tick <input type="checkbox"/>	 <b>TS 1003</b> Please Tick <input type="checkbox"/>	 <b>TS 1004</b> Please Tick <input type="checkbox"/>
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Expected Date of Tombstone Arrival	D D M M M Y Y Y Y	Expected Time of Tombstone Arrival	
Physical Address of Place of Tombstone Delivery			Country
			Code
Selected Tombstone Reference Number Above			
Name of Claimant			Cell Number of Claimant
Landline of Claimant			Alternate Contact Number

### D. DOCUMENTS TO BE ATTACHED (Mark with "X")

Repatriation	Death Certificate	
Tombstone	Permit from City Parks and/or cemetery to erect the Tombstone to the respective burial spot. The content of the engraving is to be provided	

**Notes:**  
 In some instances, further documents and/or information may be required.  
 All documents required in this Form B must be submitted and failure to do so timeously may result in the claims being repudiated.  
 The Claims are assessed on receipt of electronic claim packs.  
 Repatriation can only be conducted by our service provider. No cash will be refunded if any other service providers are used.  
 Preferred Tombstone must be selected within 90 days and erected within 15 months from date of death, otherwise the benefit will lapse.  
 The Tombstones photos are only to show design of Tombstones and additional items thereon are not included in the benefit.  
 Engraving on the Tombstone is limited to the name of the deceased plus 50 letters.

Type of Claim	Electronic	Fax	Telephonic Queries	Postal Address
Repatriation and/or Tombstone	ccnprisk@saquantum.co.za	086 644 4841	010 003 6500	SA Quantum, Risk Administration Manager, Death Claim, PO Box 781687, Sandton; 2146

### E. DECLARATION

The declaration made under Form A, will apply *mutatis mutandis* in Form B

<b>Name of Claimant</b> _____	<b>Signature of Claimant</b> _____	<b>Date Signed</b> _____
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### F. IMPORTANT NOTE

The Fund's Benefits are administered by the following Service Providers:  
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