YAMBU DOMESTIC CARE MATERNITY CLAIM FORM

1.	**What is the name of the** YAMBU Domestic Care Policy Holder:		
2.	State the Yambu Domestic Care Membership Number:		
3.	Details of Claimant (the person who is lodging a claim for policy benefits).	Name:	
		Surname:	
		ID Number:	
		Tel/Cellular Number:	
		E-mail Address:	
		Address:	
4.	In what capacity do you claim Yambu Domestic Care policy benefits?	MAIN MEMBER	
		Spouse	
		Beneficiary	
		Executor/ Executrix	
		Other (please specify):	
5.	• If the claimant is the SPOUSE of the MAIN MEMBER, you will be required to provide us with a certified copy of your marriage certificate or a sworn affidavit in confirmation of a customary union.		

6.	Have you previously claimed any benefits from YAMBU Domestic Care?	**Yes**		**No**	
7.	Is there any other current claim submitted to YAMBU Domestic Care on the life of the same Life Assured?	**Yes**		**No**	

Maternity Benefit Claim	
Date of birth of the child:	

SUPPORTING DOCUMENTATION REQUIRED

Items marked with an **X** are compulsory. Items not marked will depend on the nature of the status of the Claimant.

A certified copy of the life assured's Identity Document:	**X**
Proof of income prior to claim (salary slip):	**X**
A certified copy of the claimant's Identity Document:	**X**
Certified copy of birth certificate of child:	**X**
A certified copy of the life assured's Marriage Certificate:	**–**
A sworn affidavit in support thereof that the life assured was in a customary/ common law union with the claimant.	**–**
A sworn affidavit in support of the relationship between the claimant and the life assured.	**–**
A recent (not older than 3 months) bank statement of the Claimant's bank account:	**X**

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Date the spouse was added to the policy?	
Does the claimant qualify for the death benefit?	
Have all documents been appropriately Certified/Stamped?	
Have all the required documents been received?	

CLAIMANT'S FULL NAME & SURNAME:		**CLAIMANT'S SIGNATURE:**		**DATE:**	

KINDLY NOTE:

YAMBU Domestic Care is committed to the quick finalization of your claim, but in the absence of duly certified and proper documentation submitted to us as required, your claim will be delayed as no payout of benefits can be made until we have received ALL documents.

No third party payments will be made

FOR OFFICE USE ONLY					
Checked by (Full Name):		**Checked by (sign):**		**Date:**	
Authorised by (Full Name):		**Authorised by (sign):**		**Date:**	