Retrenchment Benefit Claim Form

Ground Floor, Trust Centre Building, Cnr Werner List & John Meinert Streets,
Windhoek, Namibia. P.O Box 41153, Ausspannplatz, Windhoek, Namibia.
Tel 061 236 585, Fax 061 236 584.
windhoek@legalwise.na www.legalwise.na

NB. Please attach a certified copy of the main Member's official retrenchment letter issued by the Employer.

Terms and Conditions Apply

Please write clearly using CAPITAL letters and one letter per block. Fill in from the left and leave a blank box as a space between words.

1. Main Member's Personal Details

Membership No

Surname Title

First Name/s

ID No Date of Birth Y Y Y Y M M D D

Tel No Tel Mobile

E-Mail

2. Employer's Details

Name of Employer

Occupation

Address

Postal Code

Tel No Tel Mobile

Date of Retrenchment Y Y Y Y M M D D

Hollard/LegalWise are committed to protecting your privacy. By providing your personal information, you consent to your information being collected in order to gain access to our products and services. Your information will be used properly, lawfully, securely and transparently for the purpose for which it is intended, namely, the administration and further maintenance of your insurance product/s. You confirm that the consent provided to us, is given on behalf of yourself, your minor dependents or any other Person to be added to your Membership, where you acknowledge and warrant that you have their permission to give such consent.

You are also consenting that Hollard/LegalWise may use your information to contact you regarding changes or updates about your insurance product/s and that Hollard/LegalWise may use your information in improving our product offering. If you do not want to receive any future product or service offerings from Hollard/LegalWise, then inform Us by contacting Member Administration on +264 61 236585 .

I, the undersigned, confirm that all the details provided are correct. Further, I consent to my information being used for the purposes of LegalWise related services only.

Main Member's Signature

Date Y Y Y Y M M D D

Disablement Benefit Claim Form

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Windhoek, Namibia. P.O Box 41153, Ausspannplatz, Windhoek, Namibia.
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NB. Please attach a certified copy of the Doctor's report confirming that the main Member is disabled.

Terms and Conditions Apply

Please write clearly using CAPITAL letters and one letter per block. Fill in from the left and leave a blank box as a space between words.

1. Main Member's Personal Details

Membership No

Surname | Title

First Name/s

ID No | Date of Birth (Y Y Y Y M M D D)

Tel No | Tel Mobile

E-Mail

2. Details of Doctor who examined the main Member

Name of Doctor

Practice Address

Postal Code

Tel No | Tel Mobile

Date of Accident (Y Y Y Y M M D D)

For Office Use Only

Date that Member reported Incident (Y Y Y Y M M D D)

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I, the undersigned, confirm that all the details provided are correct. Further, I consent to my information being used for the purposes of LegalWise related services only.

Main Member's Signature

Date (Y Y Y Y M M D D)