



CHILDREN FUNERAL BENEFIT CLAIM FORM

PRINCIPAL MEMBER DETAILS

Full Names: _____

M/NO: _____ ID/NO: _____ PF/NO: _____

Mobile No: _____

P/ Station: _____ Formation: _____

AUTHORIZED EMPLOYER REPRESENTATIVE (OCS, OCPD, OC, CO, HR)

Full Names: _____

Mobile No: _____

DECEASED CHILD DETAILS

Name: _____ BC/ID No.: _____

Date Of Birth: _____ Date Of Death: _____

I am the Parent to the above mentioned deceased person. I kindly request to be paid the Child Funeral Benefit. I declare that the information I have given is true, and I shall be legally held liable in the event the same is found to be untrue.

N/B

*Claim should be made within 6 months of the demise

*Proof of dependency will be required for children above 18 years

Signature: _____

Date: ____ / ____ / ____