



**APPLICATION FOR COMPENSATION
IN TERMS OF THE RULES OF THE ASBESTOS RELIEF TRUST
AND/OR THE KGALAGADI RELIEF TRUST
(TO BE COMPLETED IN BLACK INK)**



I, _____ (full names) being the lawful dependant / representative of the lawful dependant/s of the under-mentioned deceased ex-employee / environmentally exposed individual (*delete whichever is not applicable*) hereby apply for an award in accordance with the rules contained in the Trust Deed of the Asbestos Relief Trust and, or, the Kgalagadi Relief Trust.

The deceased was exposed to asbestos dust and fibre and was certified/diagnosed as having suffered from an asbestos-related cancer.

PARTICULARS OF THE CLAIMANT (DEPENDANT)

CLAIM REF No.:

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Surname: _____
First Name/s: _____
ID No.:

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 Date of Birth: _____
Passport No.:

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 Travel Doc No.: _____
Postal Address: _____
Physical Address: _____
Contact Details: _____

PARTICULARS OF THE DECEASED

Surname: _____
First Name/s: _____
ID No.:

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 Date of Birth: _____
Passport No.:

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 Travel Doc No.: _____
Cause of Death: _____ Date of Death: _____
Relationship: Husband Wife Mother Father Other: _____

DETAILS OF DEPENDANTS

The deceased had the following dependant/s for whom he/she provided financial support:

1) _____	AGE: _____	ID No.: _____
2) _____	AGE: _____	ID No.: _____
3) _____	AGE: _____	ID No.: _____
4) _____	AGE: _____	ID No.: _____
5) _____	AGE: _____	ID No.: _____

Reason for dependency (*please tick the appropriate box*):

- Being the deceased's lawfully married spouse, including marriage by way of customary union
- Being the lawfully appointed guardian of the deceased's minor dependent children
- Other (*please specify*): _____

IMPORTANT NOTICE:

PLEASE NOTE that proof of dependency must be submitted before a potential claim can be progressed. These documents do not have to be re-submitted if it was originally submitted with the "Occupational Enquiry Registration Form".

APPLICATION FOR COMPENSATION (continued)

AUTHORISATION

- 1) *I hereby authorise the ART and, or, the KRT, whichever is applicable, to obtain copies of the deceased's medical and other records at the Medical Bureau for Occupational Diseases and, or, the Compensation Commissioner for Occupational Diseases;*
- 2) *I have been advised of the potential award payable to me and am aware that adjustments may be made to the award amount if new information which affects the award calculation is received by the ART and, or, the KRT, whichever is applicable, prior to the payment of the award;*
- 3) *I agree that, in the unlikely event that adjustments are made, the adjusted award amount can be paid into my nominated bank account without the ART and, or, the KRT consulting me on the new award amount;*
- 4) *The contents of the Release and Discharge form have been explained to me and I understand the form;*
- 5) *By participating in this process, I understand and agree that the information provided herein as well as any medical and compensation information obtained by the ART/KRT as a result of my claim application may be used for research, statistical and other reporting/research purposes and that the results may be published. I understand that the ART/KRT undertake to ensure confidentiality and anonymity of the information used for the abovementioned purposes at all times;*
- 6) *I confirm that to the best of my knowledge and belief, the information contained in this application is true and correct, and that all documents and copies supplied by me are authentic and true copies of the original documents.*

Signed at _____ on the _____ day of _____ 20_____.

Claimant:

Witnesses:

1) _____

Name: _____

ID Number: _____

2) _____