Associated Insurance Brokers Cape
In partnership with glacier by Sanlam

Associated Insurance Brokers Cape 2006 (Pty) Ltd
Reg No 2005/026692/07 Licensed financial services provider (No 31032)

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CLAIM FORM: PERSONAL ACCEPTANCE

Reset Submit

QUESTIONS	ANSWERS
Insured	
Policy Number	
Name of Insured	
Address	
Insured VAT Registration Number	
Tel. No.	Home: Work: Cell:
Insured Person	
Name	
Age	
Business or occupation	
Relationship	
If employee, give annual earnings defined in the policy	
If other, specify relationship	
Injuries	
When did the accident occur?	
Where did the accident occur?	
Give full particulars of the accident and nature of injuries	
Witness	
Name & address	
Doctor	
Name & address of doctor who attended you	
Name & address of your usual doctor	
Disablement	
Period of temporary total disablement	
Period of temporary partial disablement	
Give date normal occupation resumed	
Has any permanent disablement resulted? If YES give details	
Previous claims	
Give details of all claims made against Insurers or in terms of WCA by the insured person	
Other Insurance	
Is there any other insurance	YES NO
With whom insured person is insured?	
If so, give name of Insurer	

Authority of payment INSURED'S BANKING DETAILS

It is recommended that if any amount is payable directly to you, it be transmitted by Electronic Bank Transfer for speedier settlement and security reasons. If you are agreeable to this, please complete and provide the following information

Name of Bank	
Account No.	
Account Type	
Branch & Code No.	
Name of account Holder	

Declaration

Insured Signature

I hereby declare that the above and foregoing particulars to be true in every aspect

I hereby authorise any hospital, physician or other person who has attended or examined me to furnish to the company or its authorised representative, all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

Capacity: _____

Date: _____

MEDICAL EXAMINATION FORM

THIS FORM MUST BE COMPLETED BY THE DOCTOR CONSULTED

The patient must obtain, at his own expense, the following certificate from a duly qualified and registered Medical Practitioner.
When the patient is fully recovered a Doctor's certificate to that affect should be forwarded to the Insurers showing the periods of partial or total incapacity

QUESTIONS	ANSWERS
Name of Patient	
Height	
Mass	
When did you first attend upon the patient in consequence of the accident for injuries sustained?	
Are you still in attendance?	
Are you the usual medical attendant of the patient, and if so, how long have you known him / her?	
What was the cause of the accident so far as known?	
What injuries were sustained?	
Region injured (if a hand, arm, foot or leg, state whether it is L / R)	
Are the symptoms from which he / she suffers due to:	
i) the accident alone, or	YES NO
ii) are they traceable to any other cause?	YES NO
Have you any reason to suspect that the patient was not perfectly sober at the time of the accident?	
Is the patient now, or was he / she at the time of the accident subject to or suffering from any illness or disease irrespective of the accident for which the benefit is claimed? If so, state the nature of same, and to what extent the recovery of the patient may be affected thereby.	
Are you the usual medical attendant of the patient?	YES NO
Are you aware of anything in his / her previous medical history which might have contributed directly or indirectly to the occurrence of the accident, or which may be likely to retard in any way recovery from it?	YES NO
Is patient confined to bed, bedroom or house by your directions?	YES NO
Has patient at any time been so confined since the date of the accident? If so, give the dates	YES NO
If so confined, please state: a) your opinion as to the probable duration of such confinement. b) Probable date of being able to resume some portion of usual business or occupation.	
Are you prepared to testify that the patient is TOTALLY disabled from attending to any portion of his / her business or occupation	YES NO

TEMPORARY TOTAL DISABLEMENT occurs when through bodily injury, the patient is immediately and continuously incapacitated for a specific period from attending to business or occupation of any kind.

If patient has been able to attend to a PORTION only of his usual business or occupation, and if this still continues, please state since when and also the probable date of recovery	

TEMPORARY PARTIAL DISABLEMENT arises when the injury does not wholly prevent the patient from attending to business, or when Temporary Total Disablement ceases and he / she can attend to some portion of his / her usual business or occupation, but not the whole.

If patient has recovered, please state date of recovery	
GENERAL REMARKS |	

Signature	I certify that the aforegoing statements are correct
	Name:
	Qualifications:
	Address:
	Date: