

CLAIM FORM: PERSONAL ACCIDENT

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 foregoing statements are correct

Name:

Qualifications:

Address:

Date: