GROUP PERSONAL ACCIDENT / STATED BENEFITS CLAIM FORM

This form is required in order to assess a pending claim under a Policy of Insurance. Issue and completion of this form does not in any way imply, construe or admit liability by the Insurers or their representatives.

Only a fully completed and signed claim form can receive further consideration.

Section 1,2,3 and 4 are to be completed by the Insured Group or the Subsidiary claiming and Section 5 by the Medical Attendant.

Please note that payment for any expenses incurred in the completion of this form is the responsibility of the claimant and not the Insurer and / or anyone representing the Insurer.

Note that original medical accounts are required for reimbursement of medical expenses. In the event that the claim is in respect of a shortfall after any Medical Aid payments then a copy of the statement from the Medical Aid society is required.

On completion of this form, please forward to your broker.

Section 1 – General Information (to be completed by the Insured Group)

Title of insured group	
Name of the Subsidiary? (if any)	
Policy Number	
Full names of the insured person	
Date of Birth	
Identity Number	
Occupation	
Date of Accident	
Time of Accident	
Place of Accident	

Details of how the Accident occurred: (If due to a motor vehicle accident, please provide the police road accident report. If the accident occurred due to a work-related injury then the statutory incident report from the immediate manager is to be provided. Any other incident can be supported by an independent witness statement if available.)

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Section 2 – Death Claim

Date of Birth	
Place	
Exact cause of Death and any factors connected therewith	

The following information is required:

- Certified copies of the abridged and final Death Certificate
- Certified copy of the Postmortem Report
- Certified copy of the Inquest Report, including all witness statements pertaining thereto.
- The Police accident report if the Death was due to a motor vehicle accident.
- The Police station reference number if the Death is due to a Criminal Investigation.
- Any newspaper clippings, eyewitness statements or incident report / official hearings that are available.

Section 3 – Disability Claim

Details of the injuries sustained by the Insured Person	
Details of the attending Doctor	
Name	
Telephone Number	
Address	

Please state the period during which the Insured Person was Totally Disabled from attending to his/her usual occupation:

From (both days inclusive)		To	

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Is the Insured Person still receiving treatment from a Medical Practitioner?	Yes ◯	No ◯
If yes – please give details		

Details of any Permanent Disability sustained as a result of this accident

Authorisation to be completed by the Insured Person or his/her Legal Representative.

I hereby authorise any hospital, physician or other person who has treated me to furnish the Insurers or their representatives with all information with regard to any injury, illness, medical history, consultations, medication or treatment, including copies my hospital medical records. I agree that a photocopy, fax or e-mail of this authorisation shall be accepted as an original.

Signed ..... Dated ..... / ..... /20 .....

Please note that payment for any expenses incurred in the completion of this claim form is the responsibility of the claimant and not the Insurer and/or any person representing the Insurer.

Note that the original medical accounts are required for reimbursement of medical expenses. In the event that a claim is in respect of a shortfall after any Medical Aid payments then a copy of the statement from the Medical Aid must be attached to this claim form.

Section 4 – Employers Certificate

Full Name of Employer		
Full Name of the Insured Person		
Category within which the Insured Person falls under the Policy		
Was the Insured person in your direct employment or that of a Sub-Contractor at the time of the Accident?	Yes ◯	No ◯
State fully the nature of the Insured Person's occupation and daily duties		

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Stipulate the Insured Person's Weekly/Monthly earnings (Please attach pay slip or IRP5)		
Is there any Compensation payable in terms of the Workmen's Compensation Act or any other Insurer ?	Yes ◯	No ◯
If yes – please provide details		

Declaration by the Employer:

I / We hereby declare the forgoing particulars to be true and accurate in every respect.

Name: .....

Capacity: .....

Signature: ..... Dated ..... / ..... /20 .....

Section 5 – Certificate from usual Medical Attendant

Full Name of Patient	
Describe how the Accident occurred	

Date of Accident	
Place of Accident	

Please state the exact cause and nature of the Disability and any important factors connected therewith

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Does the present Disability relate in any way to previous injuries or pre-existing conditions of illness?	Yes ◯	No ◯
If yes – please provide details		
What is the probable date of stabilization ?		
In your opinion, what percentage of Permanent Disability can be ascribed to these injuries only		
Please state any further information that has not already been mentioned which may be relevant to the assessment of any Disability arising from the Accident		

If any other attending Doctor – please provide details			
Name and Surname			
Address			
Telephone No.		Email Address	

Signed: ..... Dated ..... / ..... /20 .....

Full Names			
Postal Address			
Telephone No.		Email Address	