GROUP PERSONAL ACCIDENT / STATED BENEFITS CLAIM FORM

INSURED

Title of the Insured Group

Title of the Subsidiary (if applicable)

Full name of the insured person

Policy No | Date of Birth

ID No | Occupation

Date of Accident | Time am/pm

Place of Accident

Details of the occurrence

Sections 1 and 3 are to be completed by the Insured Group or the Subsidiary and Section 3 by a Medical Attendant. Please attach proof of current earnings, i.e. pay slip or letter of confirmation of earnings signed by the employer.

Note that the 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

SECTION 1 – DEATH OR INJURY

Date of Death/Injury | Place

Exact cause of Death/Injury

The following documents (where applicable) are required:

1. Certified copies of the abridged and final Death Certificate.
2. Certified copy of the Post Mortem Report.
3. Certified copy of the Inquest Report, including all witness statements pertaining thereto.
4. The Police accident report if the Death/Injury was due to a motor accident.
5. The Police Station reference number if the Death/Injury is subject to a criminal investigation.

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SECTION 2 – DETAILS OF ATTENDING MEDICAL PRACTIONER

Name of the attending Doctor | Tel No

Address

Code

Period during which the insured person was incapacitated and unable to attend to his/her usual occupation: From | To

Date on which the insured person resumed work:

Is the insured person still receiving treatment from a Medical Practitioner?: Yes ☐ No ☐

If Yes, please give full details

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

SECTION 3 – EMPLOYERS CERTIFICATE

Full name of Employer

Full names of the insured person

Category within which the insured person falls under the policy

At the time of accident, was the insured person in your employment: Yes ☐ No ☐

State fully the nature of the insured person/s occupation and daily duties

Stipulate the insured person's week/monthly earnings R

Is there any compensation payable in terms of the Workmen's Compensation Act (COIDA) or any other insurer: Yes ☐ No ☐

If YES, please provide further details

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DECLARATIONS

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, sickness, medical history, consultations, medication or treatment, including copies of my hospital medical records. I agree that a photo copy or fax copy of this authorisation shall be accepted as an original.

Signature of insured person or authorised person

Date / /

SIGNATURE AND DECLARATION OF INSURED (EMPLOYER)

I / We warrant the truth of the answers to the above questions and I / We declare that no information has been withheld and / or that any misrepresentation has been made and that the amount claimed represents my / our loss arising from the above stated occurrence.

Signature of Insured (Employer)

Date / /