



Factory & Industrial
PROTECTING THE VALUE BUSINESS CREATES

GROUP PERSONAL ACCIDENT CLAIM FORM

This form is required in order to access 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 excess incurred in the completion of this form is the responsibility of the claimant and not the Insurer and/or anyone representing the Insurer.

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 - GENERAL INFORMATION

Title of the Insured Group	
Title of the Subsidiary (if applicable)	
Full name of the Insured Person	
Policy No.	Date of Birth day / month / year
ID No.	Occupation
Date of Accident day / month / year	Time am/pm
Place	
Details of the Accident occurred	

SECTION 2 - DEATH CLAIM

Date of Death day / month / year	Place
Name of person conveying cash	
How long has he/she been in your employ	
Does he/she regularly convey your cash ☐ YES ☐ NO	
Exact cause of death and any factors connected therewith	
(cont)	

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SECTION 2 - DEATH CLAIM (cont)

The following information is 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 was due to a motor accident.
5. The Police Station reference number if the Death is subject to a Criminal investigation.
6. Any newspaper clippings, eye witness statements or incident reports that are available.

SECTION 2 - DISABILITY CLAIM

Details of the injuries sustained by the Insured Person

Name of the attending Doctor

Tel No.

Address

Code

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

From

To

(both days inclusive)

Date on which the Insured Person resumed work

day / month / year

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

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

Date

day / month / year

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SECTION 4 - 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 the accident, was the Insured Person in ☐ Your direct employment ☐ That of a Sub-contractor

State fully the nature of the Insured Person's occupation and daily duties

Stipulate the Insured Person's weekly/monthly earnings

Is there any compensation payable in terms of the Workmen's Compensation Act or any other insurer

☐

YES

☐

NO

If YES, please provide further details

DECLARATION BY THE EMPLOYER

I/We hereby warrant the truth of all the particulars on this form in every respect and declare that the conditions of this Insurance have been complied with.

Please attach proof of current earnings paid to the Insured Person.

Name

Signature of insured

Capacity

Date

day / month / year

Company stamp

SECTION 5 - CERTIFICATE FROM USUAL MEDICAL ATTENDANT

Full name of Patient

Describe how the accident occurred

Date of Accident

Place

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

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SECTION 5 - CERTIFICATE FROM USUAL MEDICAL ATTENDANT (cont)

Does the current disability relate in any way to previous injuries or pre-existing conditions or illness

☐

YES

☐

NO

If YES, please give further details

Name of other attending Doctor

Code

What is the probable date of stabilisation

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 from the accident

Full name

Code

Postal Address

Code

Business Tel No.

Signature

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