PERSONAL ACCIDENT (INJURY / ILLNESS) CLAIM FORM

INSURER		**POLICY NUMBER**	**VAT REG NUMBER**
INSURED	Name & Occupation		
	Address & Phone No.		
INSURED PERSON	Name & Age		
	Business or Occupation		
	Address & Phone No.		
RELATIONSHIP OF INSURED PERSON TO THE INSURED	If employee give annual earnings defined in the policy		
	If other, specify relationship		
INJURY / ILLNESS	When and where did accident occur or illness commences?	Date	Time	Place
	Give full particulars of the accident and nature of injuries or the name of the illness		
WITNESS	Name & Address		
DOCTOR	Name and address of doctor who attended to you		
	Name and address of your usual doctor		
DISABLEMENT	Period of temporary total disablement	From	To
	Period of temporary partial disablement	From	To
	Give date normal occupation resumed	Date	
	Has any permanent disablement resulted? Give Details		
OTHER INSURANCES	Give name of any other insurer with whom insured person is insured		
PREVIOUS CLAIMS	Give details of all claims made against insurers or in terms of the WCA by the insured person.Compensation for Occupational Injuries and Diseases Act No. 150 of 1993		
DECLARATION / AUTHORISATION	CONSENT TO DISCLOSURE You acknowledge that the sharing of claims information and underwriting information (including credit information) by Insurers is essential to enable the Insurance Industry to underwrite policies and assess risks fairly and to reduce the incidence of fraudulent claims, in the public interest and with a view to limiting premiums. On behalf of Yourself and on behalf of any person You represent herein, You hereby waive any right to privacy in any insurance information provided by You or on Your behalf in respect of any insurance policy or claim made or lodged by You and You consent to such information being disclosed to any other insurance company or its agent. You also acknowledge that the information provided by You may be verified against other legitimate sources or databases. You also waive any rights of privacy and consent to the disclosure of any information relevant to any insurance policy or claim concerning Yourself. We hereby declare the foregoing particulars to be true and complete and correct in every respect		
	Insured's Signature	Capacity	Date
	IMPORTANT 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 photostat copy of this authorisation shall be considered as effective and valid as the original.		
	Insured Person's Signature		