ASSOCIATED INSURANCE BROKERS

Reg No 2004/022911/07

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INJURY / ILLNESS CLAIM FORM

POLICY NUMBER		
INSURED	Name and business	
	Address and Day Telephone Number	
INJURED PERSON	Name and age	
	Business or occupation	
RELATIONSHIP OF INJURED PERSON TO INSURED	If employee give annual earnings defined in the policy	
	If other, specify	
INJURY / ILLNESS	When and where did accident occur or illness commence?	DATE TIME PLACE
	Give full particulars of the accident and nature of injuries or the name of the illness	
WIT-NESS	Name and address	
DOCTOR	Name and address of doctor who attended 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 INSURA-NCES	Give name of any other insurer with whom injured person is insured.	
PREVIOUS CLAIMS	Give details of all claims made against insurers or in terms of the WCA by the injured person	

DECLARATION / AUTHORISATION

I/We declare that the above particulars are true in every respect

Signature of Insured	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 the authorisation shall be considered as effective and valid as the original.

Insured person's signature ……..

MEDICAL CERTIFICATE

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 effect should be forwarded to the insurers showing the periods of partial and total incapacity.

NAME OF PATIENT: ……..…… HEIGHT …… MASS ……..

1. When did you first attend upon the patient in consequence of the Accident / Illness sustained?

   .....

2. Are you still in attendance?.....

3. Are you the usual medical attendant of the Patient, and if so, how long have you known him / her?

   .....

4. What was the cause of the Accident / Illness as far as known?

   .....

5. What injuries were sustained? .....

   a) region injured (if hand or an arm, a foot or a leg, state whether it is the right or the left)

   .....

   b) are the symptoms from which he / she suffers due to:
   (i) the accident / illness alone? .....

   (ii) are they traceable to any other cause? .....

6. Have you any reason to suspect that the Patient was not perfectly sober at the time of the Accident?.....

7. Is the Patient now, or was he/she at the time of the Accident/ Illness subject to or suffering from any illness or disease irrespective of the Accident / Illness 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.

   .....

   .....

8. If you are the usual Medical Attendant of the Patient, are you aware of anything in his/her previous medical history, which might have contributed directly or indirectly, to the occurrence of the Accident/Illness, or which may be likely to retard in any way recovery from it?

   .....

   .....

9. (a) Is Patient confined to bed, bedroom, or house by your directions? .....

   (b) Has patient at any time been so confined since the date of the Accident/Illness? If so, give the dates. .....

10. If still 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 .....

11. Are you prepared to certify that the Patient is TOTALLY disabled from attending to any portion of his / her business or occupation?

    .....
    (TEMPORARY TOTAL DISABLEMENT occurs when through accidental bodily injury or illness, the Patient is immediately and continuously incapacitated for a specific period from attending to business or occupation of any kind.)

12. If Patient has been able to attend to a PORTION only of his/her usual business/occupation please state, when and also the probable date of recovery.

    (TEMPORARY PARTIAL DISABLEMENT arises when the injury or illness 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.

13. If Patient has recovered, please state date of recovery. .....

GENERAL REMARKS:.....

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I certify that the aforegoing statements are correct Name:.....

Signature: ..... Qualifications:.....

Date: ..... Address: .....