

**INJURY / ILLNESS CLAIM FORM**

Tel: 011 803 7446

Fax: 011 807-6861

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 commence?	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	I / We declare that the above particulars are true 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						