INSURANCE UNDERWRITING MANAGERS

Personal Accident and Stated Benefits Claim Form

INSURED	Policy number		Name	
	Identity number		Occupation	
	Contact number			
	Physical address			
INCIDENT DETAILS	Date and time		When discovered	
	Place of incident			
	Describe fully how the incident occured:			
	If incident was caused by another party provide name and address			
	Name		Address	
DEATH CLAIM	Date		Place	
	Cause of death			

The following documents must be submitted as and when made available:

- Certified copies of the Abridged and Final Death Certificate
- Certified copy of the Post Mortem Report
- Certified copy of the full Inquest Report including all witness statements
- Certified copy of the SAPS Accident Report in the event of a motor vehicle accident
- SAPS Case Number in the event of a criminal investigation
- Any other documents relevant to this incident

DISABILITY CLAIM	Disability claim			
	Details injuries sustained			
	Name of doctor		Contact number	
	State the period during which the insured was unable to work as a result of the disability			
	Is the insured still receiving treatment?	Yes: ◯	No: ◯	
	If yes, give details			
	Details of permanent disability sustained as a result of this accident			

The following documents must be submitted as and when made available:

- Copies of medical records relevant to injuries and disability sustained by insured

EMPLOYMENT DETAILS	Name of employer		Contact number	
	Employee full-time when incident occured?	Yes: ◯	No: ◯	
	State the nature of the employee's occupation and daily duties			
	Weekly earnings		Monthly earnings	
	Medical expenses / compensation payable in terms of Workmen's compensation act or other insurer?		Yes: ◯	No: ◯

	If yes, give details	

Please provide copies of the following documents:

- Copy of employee's Payslip
- Copy of employee's Job Description
- Copy of Workmen's Compensation submission, if applicable
- Copy of any claim submitted to other insurer's, if applicable

DECLARATION

We hereby declare the following particulars to be true in every respect.

Signature of driver: _____ Date: _____

Signature of insured: _____ Capacity: _____ Date: _____

It is important that you notify the insurers immediately should you become aware of any impending prosecution, inquest or demand.

Any personal injuries noted overleaf must be reported separately to the multilateral motor vehicle accident fund without delay.