GUARDRISK
TAILORED RISK SOLUTIONS
A subsidiary of **MMI Holdings**

ACCIDENT AND HEALTH CLAIM FORM

This form is required in order to assess a potential claim under a policy of insurance. Issue and completion of this form does not in any way imply, construe or admit liability by the insurer. Only a fully completed and signed claim form can receive our further consideration. All claims to be reported to a&hclaims@guardrisk.co.za

Section 1: General

Policy number	
Name of insured	
Name of injured person	
ID number of injured person	
Occupation of injured person	
Date of accident	
Time of accident	
Place of accident	
When did the injury occur? (ie; on duty, during business activity etc)	
SAPS and OAR case number	
Give a detailed description of how the accident occurred	

The following documentation must be provided for this claim to be considered:
NOTE: It is not necessary to have all these documents when submitting the claim. These documents can be forwarded at a later stage to avoid any unnecessary delays.

- Copy of the insured's ID
- Copy of the Injury on Duty Reporting (IOD) the event of an injury during business hours/ activities - where applicable
- Copy of accident report
- Copy of the OAR (Police report) in the event of a motor vehicle accident - where applicable
- Details of witnesses
- Copy of the injured's salary slip - where applicable

Section 2: Death Claim (if applicable)

Date and place of death	
State the exact cause of death and any important factors connected therewith	

The following documentation must be provided for this claim to be considered:
NOTE: It is not necessary to have all these documents when submitting the claim. These documents can be forwarded at a later stage to avoid any unnecessary delays.

- Death Certificate
- Post Mortem Report
- Report for occupational related death
- Police Accident Report if death was due to a motor vehicle accident
- Police Reference number if death is the subject of a criminal investigation
- Copies of any newspaper clipping or eye witness statements that may be available

Section 2B: Final Rest

- Certified Death Certificate
- Post Mortem
- Incident Report

Section 3: Disability claim (if applicable)

Give full details of the injuries sustained by the claimant	
Name of attending doctor	
Practice number	
Tel no.	
Address	
Please state the period which the claimant was totally disabled from attending to his/ her usual occupation	
From	
Please state the date upon which he/she resumed ligh duties	
Has any permanent disablement resulted from this accident, if yes, please give details	

Section 4: Medical Expense (if applicable)

The following documents will be required when claiming for medical expense:

- An original Medical Aid account proving admission into hospital and discharge dates is required when claiming under this section.
- Receipts for accounts which the claimant has already settled

Section 5: Temporary Income Replacement (TTD) (if applicable)

The following documents will be required when claiming for Temporary Income Replacement (TTD)

- Confirmation of earnings
- Medical report
- If involved in a motor accident, a police/ accident report

Give full details of the injuries sustained by the claimant	
Name of the attending doctor	
Practice number	
Tel no.	
Address	

AUTHORISATION

Authorisation to be completed by the claimant or his/her legal representation

I hereby authorise any hospital, physician or any other person who treated me, to furnish the insurer or the legal representatives with all information with regard to any injury, sickness, medical history, consultations, prescription or treatment including copies of all my hospital or medical reports. I agree that a photostat/ fax copy of this authorisation shall be accepted as the original. I declare that the answers given by me in this claim form are true in every aspect.

Signature of the claimant or his/her legal representation ____________________________

Date ____________________________

Place ____________________________

Section 6: Hospitalisation Benefit

The following documents will be required when claiming for the Hospitalisation Benefit

- Original medical accounts proving admission into hospital and discharge dates

AUTHORISATION

Authorisation to be completed by the claimant or his/her legal representation

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Signature of the claimant or his/her legal representation ____________________________

Date ____________________________

Place ____________________________

EMPLOYER CERTIFICATE

This section is to be completed by the salaries or human resources department

Full name of claimant	
Is the claimant a full time permanent employee	
Please confirm the disability and dates of absence from work stated in this claim form are correct	
State fully the nature of the claimant's occupation and daily duties	
In the case of Injury on Duty (IOD) please confirm and provide the following	
Was this IOD reported?	

MEDICAL CERTIFICATE

This section is to be completed by the doctor consulted

The claimant must obtain, at his/ her own expenses, the following certificate from a duly qualified and registered medical practitioner who treated him/ her for his/her injuries. When the claimant is fully recovered, a doctor's certificate to that effect must be forwarded to the insurer showing the periods of partial and total incapacity.

Full name of patient	
When you were first consulted by the claimant in connection with his/her injuries	
Are you still in attendance	
What was the cause of the accident so far as known	
What injuries were sustained	
Please state the exact cause and nature of the disability and any other important factors connected therewith	
Does the present disability relate in any way to previous injuries or pre-existing conditions or illness	
If yes, please explain	
Is the patient now or was he/she at the time of the accident subject to or suffering any illness or disease irrespective of the accident for which the benefit is claimed?	
If so, state the nature of it, and to what extent the recovery of the patient may be effected thereby	
Is the patient temporarily or permanently disabled from attending to any portion of his/her usual business of occupation	
If yes, please explain	
Please stated any information not already mentioned which is relevant to the assessment of any permanent disability arising from the accident	
If the patient has fully recovered, please state the date of recovery	

In the event of serious illness confirm and provide the following:

Was this a newly diagnosed illness	**YES**	**NO**
Date of diagnosis		
Type of illness		
Have you claimed, from this policy, for any of these illnesses before?	**YES**	**NO**
	If yes, please give details	
	Type of illness	
	Date of diagnosis	
	Date of payment	
When did symptoms first appear?		
When did you first consult a doctor for this condition?		
Name, address and telephone number of the doctor consulted		
Name, address and telephone number of the hospital(s) you have been treated at for this condition		
Details of medical assistance sought in the last 5 years (minor illnesses such as colds and flu may be omitted)		
Name, address and telephone number of your usual doctor		

AUTHORISATION

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Signature of the claimant or his/her legal representation ____________________________

Date ____________________________

Place ____________________________

SERIOUS ILLNESS MEDICAL CERTIFICATE

This section is to be completed by the doctor consulted

The claimant must obtain, at his/ her own expenses, the following certificate from a duly qualified and registered medical practitioner who treated him/ her for his/her injuries. When the claimant is fully recovered, a doctor's certificate to that effect must be forwarded to the insurer showing the periods of partial and total incapacity.

Section 1: General

Patient's name		
Age of patient		
Are you the patients usual medical attendant?	**YES**	**NO**
	If yes, please give details of the patients medical/ surgical history for the last 12 months prior to hospitalization	
When did the patient first become aware of the symptoms?		
When did the patient first become aware of the symptoms?		
Has the patient suffered from this disease in the past?	**YES**	**NO**
	If yes, please give details	
When was medical advice sought?		
Do you know of any other hereditary disease in the patients family?	**YES**	**NO**
	If yes, please provide details	
Do you know of any factors regarding past or present health, habits or lifestyle which may have contributed to any health problems?	**YES**	**NO**
	If yes, please provide details	
Do you know of any hereditary disease in the patient's family?	**YES**	**NO**
	If yes, please give details	

Select the applicable illness (x)

Cancer		Motor Neuron Disease (resulting in permanent symptoms)		Paraplegia	
Coronary Artery Surgery		Alzheimers		Multiple Sclerosis (persisting symptoms)	
Heart Attack		Coma (resulting in permanent neurological complications)		Blindness	
Stroke (resulting in permanent symptoms)		Parkinson's Disease		Major Organ Transplant	
Kidney Failure		Heart Valve Surgery			

Section 2: Cancer

This is defined as a malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma. The following conditions are excluded from this definition:

- All cancers in situ and all pre-malignant conditions
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- All skin cancers, other than malignant melanoma that has been histologically classified as having invasion beyond the epidemic (outer layer skin)

State the site and extent of the neoplasm		
Is it malignant or non-malignant?		
Has staging been carried out?	**YES**	**NO**
	If yes, please give details (please comment on invasion of metastases)	

Section 3: Coronary Artery Surgery

This is defined as the actual undergoing, on the advice of a consultant surgeon, of coronary artery bypass surgery to correct stenosis or occlusion in the coronary arteries but excluding angioplasty, keyhole surgery and other non-surgical techniques such as laser procedures.

State the type of procedure done and date perfomred	
What were the event predisposing to surgery	

Section 4: Heart Attack

This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by two of the following three criteria:

- Compatible clinical symptoms
- Characteristic ECG changes which can be either of the following:
  - New pathological Q-waves as defined below
  - ST-segment and T-wave changes indicative of myocardial ischaemia that may progress to myocardial infarction, as defined below, but only when accompanied by raised cardiac markers as described below
- Pre-intervention raised cardiac markers
  - Trop T greater than 1,0ng/ml
  - Trop I greater than 0,5ng/ml
  - CK-MB mass greater than two times the normal values in acute presentation phase or
  - Total CPK elevation of greater than two times the normal value, with at least 6% being CK-MB

The evidence must show a definite acute myocardial infarcation. Other acute coronary syndromes, including but not limited to angina, are not covered by this definition.

For purposes of this definition, new pathological Q-waves mean the following:
Any Q-waves in leads V1 through V3, Q-wave greater than or equal to 30ms (0.03s) in leads I, II, AVL, AVF, V4 V5 or V6. The Q-wave changes must be present in any two contigiuous leads, and be grater than or equal to 1mm in depth ECG changes indicative of myocardial ischaemia that may progress to myocardial infarcation, mean the following:

- Patients with ST- segment elevation
  - New or presumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to0.2mV in leads V1, V2 or V3 and more or equal to 0.01mV in other leads. Contiguity in the frontal plane is defined by the lead sequence AVL, I , inverted AVR, II , AVF , III
- Patients without ST-segment elevation:
  - ST-segment depression
  - T-wave abnormalities only

State the type and extent of the infarction		
Is there a history of chest pain?		
State the new ECG changes and the date done		
Has an ECG been done before	**YES**	**NO**
	If yes, please give details	
When was the test done and what were the cardiac enzyme levels		

State the following UP levels, if done and the dates

CPK		**AST**		**MBCK**		**CK**		**LDH**	

Section 5: Kidney Failure

This is as chronic end stage failure of both kidneys to function, as a result of which regular dialysis is necessary

Is there chronic irreversible failure of both kidneys		
Give the dates and results of the kidney function tests done		
Has regular dialysis been instituted?	**YES**	**NO**
Please state frequency of dialysis		

Section 6: Major Organ Transplant

This is defined as which shall mean the actual undergoing as a recipient of a transplant of the heart, liver, pancreas, bone marrow or at least one of the kidney's or lungs

What organ was replaced?	
What was the underlying disease?	
For how long was the disease present?	
What was the source of replacement?	

Section 7: Multiple Sclerosis

This is defined as a definite diagnosis of multiple sclerosis by a neurologist. There must be current clinical impairment of motor or sensory function of an EDSS scale 3.0 or more, which must have persisted for a continuous period of at least 6 months. Benign multiple sclerosis will not be covered.

Has the following neurological investigations been done?	Lumber puncture	**YES**	**NO**
	If yes, please provide details		
	Evoked visual responses	**YES**	**NO**
	If yes, please provide details		
	MRI scan	**YES**	**NO**
	If yes, please provide details		
Was there evidence of any lesion of the central nervous system?	**YES**		**NO**
	If yes, please provide details		

Section 8: Paraplegia

This is defined as suffering total and irreversible loss of the use of any two limbs, but excluding paraplegia caused by accidental, violent, external and visible means.

Please state the extent of the paraplegia (please tick)									
Irreversible		Permanent		Compete		Temporary		Partial	
State the limbs involved									
Please state the cause									

Section 9: Stroke

This is defined as death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent motor deficit, and confirmed with appropriate clinical findings by a specialist neurologist.
For the above definition, the following are not covered:

- Transient ischaemic attack
- Vascular disease affecting the eye or optic nerve
- Migraine and vestibular disorders
- Traumatic injury to brain tissue or blood vessels

Please state the specific type of incident	
Has this lasted for more than 24 successive hours?	
What was the cause?	
State the neurological sequelae present and how long did it last?	
Is there any permanent neurological deficit?	

Section 10: Medical Evidence / reports

Please include copies of all the relevant reports and indicate which reports are enclosed.

Histology	Radiology
Laboratory Test Results	ECG Tracings
Investigation/ Procedure	Any other documentation which may be relevant

Section 11: Medical/ Casualty Expense (if applicable)

The following documents will be required when claiming for medical expense:

- An original invoice
- Any supporting documents
- Receipts for accounts which the claimant has already settled

AUTHORISATION

Authorisation to be completed by the claimant or his/her legal representation

I hereby authorise any hospital, physician or any other person who treated me, to furnish the insurer or the legal representatives with all information with regard to any injury, sickness, medical history, consultations, prescription or treatment including copies of all my hospital or medical reports. I agree that a photostat/ fax copy of this authorisation shall be accepted as the original. I declare that the answers given by me in this claim form are true in every aspect.

Signature of the claimant or his/her legal representation ___________________________

Date ___________________________

Place ___________________________

Section 12: Broken Bones and Fractures (if applicable)

The following documents will be required when claiming for medical expense:

- An original invoice
- X-rays
- Receipts for accounts which the claimant has already settled

AUTHORISATION

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Signature of the claimant or his/her legal representation ___________________________

Date ___________________________

Place ___________________________

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Signature of the claimant or his/her legal representation ___________________________

Date ___________________________

Place ___________________________

INFORMATION SHARING - CONSENT OF INSURED

You agree to share your information

1. I acknowledge that sharing of insurance information for underwriting and claims purposes (including credit information) between insurers is in the best interest as it enables insurers to underwrite policies and assess risks fairly and to reduce the incidence of fraudulent claims with a view to limiting premiums.

2. I waive my right to privacy with regard to underwriting or claims information (including credit information) that I provide or that is provided by another person on my behalf in respect of any insurance policy or claim made or lodged by me, This is on my own behalf as well as on the behalf of any person I represent in terms of this insurance policy.

3. I acknowledge that the Insurance information provided by me may be stored in the shared database and used as set out above as well as for any decision pertaining to the continuance of my policy or the meeting of any claim I may submit.

4. I consent to such information being disclosed to any other insurance company or its agent

5. I acknowledge that the information may be verified against legally recognised sources or database.

DECLARATION

I/ we hereby acknowledge that Guardrisk Insurance Company (Pty) Ltd may make an enquiry , where applicable, to the South African Crime Burea or their authorised representatives to obtain any information or detail as being reported on this claim form.

I/ we hereby declare that the afore going particulars to be true in every respect.

Signature of claimant or his/hers legal representative ....

Name ....

Capacity ....

Date ....

Place..

N.B IT IS IMPORTANT THAT YOU NOTIFY THE INSURERS IMMEDIATELY WHEN YOU BECOME AWARE OF ANY IMPENDING PROSECUTION, INQUEST OR DEMAND.