GUARDRISK
TAILORED RISK SOLUTIONS
A member of the Alexander Forbes Group

ASSISTERE PERSONAL ACCIDENT INSURANCE 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 reported to:

Telephone 011 731 3693
Fax 011 447 0083
E-mail tewaterd@sha.co.za and attachments@sha.co.za

Section 1: General

Name of Insured	
Name of Injured employee	
Employee's Occupation	
ID Number	
Date, time & place of accident	
Is this an Injury during business hours/activities	
SAPS & 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.

1. Copy of the injured`s ID.
2. Copy of the IOD Report of an accident in the event of an Injury during business hours/activities
3. Copy of the OAR (police report) in the event of a motor vehicle accident.
4. Details of witnesses.
5. Copy of the injured's salary slip

Section 2: Death Claim (if applicable)

Date & 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.

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

Section 3: Disability Claim

Give full details of the injuries sustained by the claimant	
Name of the 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 light 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 Account proving admission into hospital and discharge dates is required when claiming under this section
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 respect.

Signature of the Claimant or his/her legal representative	
Date	
Place	

EMPLOYER CERTIFICATE
This certificates is to be completed by the Salaries or Human Resource 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 event of an IOD please confirm and provide the following

Was this IOD reported?	
Do you have a COID claims number	

Please note that the following documents must be submitted as soon as possible:

1. Employer's report of an accident or disease (Wcl1 0r Wcl2)
2. First Medical Report (Wcl4)
3. Progress or Final Medical Report (Wcl5)
4. Resumption Report (Wcl6)

Declaration by Employer

I hereby warrant the truth of all particulars on this form in every respect and declare that all conditions of this insurance have been complied with:

Signature:	
Date:	
Capacity	
Company Stamp	

MEDICAL CERTIFICATE

This certificate 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 were you 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 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 from 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 or occupation	
If yes, please explain.	
Please state 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	

DECLARATION

I hereby certify that the above statements are true in every respect.

Name:	
Qualifications:	
Signature:	
Date:	
Address:	
Telephone Number	
Practice Number	