



INJURY/ILLNESS CLAIM FORM

INSURER _____ POLICY NUMBER _____ VAT REG NUMBER _____

Insured Name and occupation _____

Address and phone number _____

Insured Person Name and age _____

Business or occupation _____

Address and phone number _____

Relationship to the Insured If employee, give annual earnings defined in the policy _____ R _____

If other, specify relationship _____

Injury/Illness When and where did accident occur or illness commence?

Date	Time	Place
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Give full particulars of the accident and nature of injuries or the name of the illness _____

Witness Name and 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