GROUP PERSONAL ACCIDENT CLAIM FORM

Old Mutual Insure Limited, Registration Number 1970/006619/06.
A licensed FSP and non-life insurer. (FSP12)

Underwritten/ Administered by Frontline Underwriting Managers (Pty) Ltd
Vat No. 4350242386 Reg. No. 2008/005015/07
Authorised Financial Service Provider: FSP No. 40752

THIS FORM IS REQUIRED IN ORDER TO ASSESS A PENDING CLAIM UNDER A POLICY OF INSURANCE. ISSUE AND COMPLETION OF THIS FORM DOES NOT IN ANY WAY IMPLY, CONSTRUE OR ADMIT LIABILITY BY THE COMPANY. ONLY A FULLY COMPLETED FORM CAN RECEIVE OUR CONSIDERATION – PLEASE PRINT, DO NOT WRITE!

Sections 1,2,3 and 4 are to be completed by the Insured Group or the Subsidiary claiming and Section 5 by the medical attendant. Please note that payment for any expenses incurred in the completion of this form is the responsibility of the claimant and not Frontline Underwriting Managers (Pty) Ltd. Also note that we require the original medical accounts to support all claims for reimbursement of medical expenses. In the event that the claim is in respect of the shortfall after any medical aid payments then a copy of the statement from the Medical Aid Society is required.

1. GENERAL

Name of the Insured Group										
Name of subsidiary (if applicable)							Policy Number			
Names and Surname of Insured Person										
Date of birth	D	D	M	M	Y	Y	Occupation			
Date of accident	D	D	M	M	Y	Y	Time		Place	
Give a detailed description of how the accident occurred										

2. DEATH CLAIM

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

THE FOLLOWING DOCUMENTS SHOULD BE PROVIDED AS IT COMES AVAILABLE

1. Certified copies of the abridged and the final death certificate
2. A certified copy of the Post Mortem report
3. A certified copy of the full Inquest Report including all witness statements pertaining thereto
4. The police accident report if death was due to a motor accident
5. The police station and reference number if death is the subject of a criminal investigation
6. Copies of any newspaper clippings, eyewitness statements or incident reports that may be available

3. DISABILITY CLAIM

Give full details of the injuries sustained by the injured person
Please state the name, telephone number and address of the attending doctor

4. EMPLOYER's CERTIFICATE

Full name of Employer
Names and surname of the Insured Person
Category within which the insured person falls under the policy
Was the insured person in your direct employment or in that of a sub-contractor at the time of the accident
State fully the nature of the insured person's occupation and daily duties
Stipulate the insured person's weekly/monthly earnings
Are any medical expenses or compensations payable in terms of a Workman's Compensation Act or by any other insurer
YES ☐ NO ☐ (tick the applicable box)
If YES, give full details

DECLARATION BY EMPLOYER

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

Signature	Name in block letters
Date	Capacity

Company Stamp

5. CERTIFICATE FROM INITIAL MEDICAL ATTENDANT

Full names and surname of patient	
Describe how the accident occurred	
Date of accident	Place of accident
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 illnesses	YES ☐ NO ☐
If YES, please elaborate	
Did any doctor other than you attend to the patient during the course of his/her disability	YES ☐ NO ☐
If YES, please state the name and address of any other attending doctor	
Name	
Address	
What is the probable date of stabilisation	
In your opinion what percentage of permanent disability can be ascribed to these injuries only	
Please state any information not already mentioned which might be relevant to the assessment of any permanent disability arising from the accident	
Signature	Full names
Postal Address	
	Postal Code
Telephone Number	

We may use your information or obtain information about you for the following purposes:

- Underwriting
- Assessment and processing of claims
- Credit searches and/or verification of personal information
- Claims checks (ASISA Life & Claims Register)
- Tracing beneficiaries
- Fraud prevention and detection
- Market research and statistical analysis
- Audit & record keeping purposes
- Compliance with legal & regulatory requirements
- Verifying your identity
- Sharing information with service providers we engage to process such information on our behalf or who render services to us. These service providers may be abroad, but we will not share your information with them unless we are satisfied that they have adequate security measures in place to protect your personal information.

You may access your personal information that we hold and may also request us to correct any errors or to delete this information. In certain cases you have the right to object to the processing of your personal information.

You also have the right to complain to the Information Regulator, whose contact details are:
http://www.justice.gov.za/inforeg/index.html
Tel: 012 406 4818
Fax: 086 500 3351
Email: inforeg@justice.gov.za