FRONTLINE
UNDERWRITING MANAGERS (PTY) LTD

GROUP PERSONAL ACCIDENT CLAIM FORM

Company Reg. No: 2008/005015/07 Vat Reg. No: 4350242386
Compliance Officer: Moonstone Compliance
Authorised Financial Service Provider – FSP No. 40752

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

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.

Sections 1, 2, 3, 4 and 5 are to be completed by the Insured Group or the Subsidiary claiming and Section 6 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. INSURED			
Policy Number:			
Name of the Insured Group:			
Name of Subsidiary (if applicable):			
Names and Surname of Insured Person:			
Occupation:			
Address:			
		Code:	
Tel. Number:	(H)	Tel. Number:	(W)
Cell Number:		Fax Number:	
E-mail:			
Identity Number:			

2. GENERAL					
Place:		Date of accident:		Time:	
Give a detailed description of how the accident occurred:					
3. DEATH CLAIM					
Place of death		Date 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 is due to a Motor Accident
5. The Police Station and Reference Number if death is subject of a Criminal Investigation
6. Copies of any newspaper clippings, eye witness statements or incident reports that may be available

4. 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:	Name of doctor:		Telephone number:	
	Address:			
5. 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 that of a sub-contractor at the time of the accident?	YES	NO	Specify:	
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	
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 insurance have been complied with

Name in BLOCK Letters		Signature:	
Capacity:		Date:	
Company Stamp:			

6. 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 yourself, 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:			
MEDICAL ATTENDANT:			
Full Names:		Signature:	
Telephone Number:		Date:	
Postal Address:			
		Code:	

FOR RECORD PURPOSES, PLEASE COMPLETE THE BELOW INFORMATION, SHOULD THE CLAIM BE APPROVED

VAT VENDOR:

Yes	No

If Yes, provide your VAT no #: _____

☐ 1. I/we confirm, that should the claim be approved in terms of the policy, the Nett amount is to be paid into the same bank account details as per the current monthly premium collection via debit order, as confirmed below:

☐ 2. I/we confirm, that should the claim be approved in terms of the policy, the Nett amount is to be paid into different bank account details, current dated proof of bank details attached and reason for not utilising existing details, as confirmed below:

CONFIRMATION OF BANK DETAILS AS INDICATED ABOVE (1 OR 2)	
BANK NAME:	
BRANCH CODE:	
ACCOUNT HOLDER:	
ACCOUNT NO:	
ACCOUNT TYPE:	
If option 2 selected the Co Insured name & signature is required:	
If option 2 selected, a Valid reason for different bank details:	
The Insured name and signature always required:	

The above has been implemented to minimise financial risk to the Insured and Insurer.

Thank you for complying.

Signed at _____ on this _____ day of _____ 20_____.

_____ _____

Insured Signature Witness

Designation: _____

DECLARATION

PLEASE READ THE FOLLOWING DECLARATION VERY CAREFULLY AND READ AGAIN THE QUESTIONS AND ANSWERS, BEFORE SIGNING THE FORM

I/We declare that the statement and particulars in this claim form are true to the best of my/our knowledge and belief and that I/we have not misstated, suppressed or omitted any material facts.

_____ _____

SIGNATURE OF INSURED **DATE**

DESIGNATION: _____

NAME IN PRINT: _____

PRIVACY NOTICE – PROTECTION OF PERSONAL INFORMATION ACT ("POPIA")

We understand that your personal information is important to you and that you may be apprehensive about disclosing it.
Your privacy is just as important to us and we are committed to safeguarding and processing your information in a lawful manner.

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.

YOUR rights
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.

To view our full privacy notice with contact details for the Information Regulator, please visit our website on:
https://frontlineinsurance.co.za/popi/