WITHOUT PREJUDICE

IMPORTANT NOTICE: Claims will only be open for a period of 6 months. Any further treatment required that may exceed the 6-month period will not be covered under the GPA Policy.

PERSONAL ACCIDENT CLAIM FORM

Insured's Name ……

Identity Number ……..…

Tel. Number/Cell Phone Number ……..…

E-mail Address ……..…

MSA Licence Number……..…

ACCIDENT DETAILS

Injury……

Date…… Venue……

Give full particulars of the accident and nature of injuries:

……

……

……

……

BANK DETAILS

All refunds payable to you will be paid via Electronic Bank Transfer. Please provide your bank details below and ensure it is correct to avoid any delays.

Name of account holder…….

Name of Bank…….

Branch (Code) ……...……

Account number…….

_____ _____

Signature of Insured Date

Stalker Hutchison Admiral (Pty) Ltd

Tel: +27 (0)11 731 3600
Fax: +27 (0)86 432 4507
www.sha.co.za

The Pavilion,
The Wanderers Office Park,
52 Corlett Drive, Illovo, 2196
P O Box 55347, Northlands, 2116

Co. Reg. No.: 1985/000368/07
VAT No.: 4310103082

MEDICAL CERTIFICATE

(Must be completed by the Doctor consulted)

The Patient must obtain the following certificate from a duly qualified and registered Medical Practitioner.

When the Patient is fully recovered a Doctor's certificate to that effect should be forwarded to the Insurers showing the periods of partial loss and total incapacity.

Name of patient ……..……

Height …… Weight ……..……

1. When did you first attend upon the Patient in consequence of the accident sustained?

   ……

   ……

2. Are you still in attendance?

   ……

3. Are you the usual medical attendant to the Patient and if so how long have you known him/her?

   ……

   ……

4. What was the cause of the accident so far as known?

   ……

   ……

5. What injuries were sustained?

   ……

   ……

   a. Region injured (if a hand or an arm, a foot or a leg, state whether it is right or left)

   ……

   b. Are the symptoms from which he/she suffers due to:

      i. The accident alone or Yes ☐ No ☐

      ii. Are they attributed to any other cause?

   ……

6. Have you any reason to suspect that the Patient was not perfectly sober at the time of the accident?

……

……

7. 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 is claimed? If so, state the nature of the same and to what extent the recovery of the Patient may be affected thereby.

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8. If you are the usual Medical Attendant of the Patient, are you aware of anything in his/her previous medical history which might have contributed directly or indirectly to the occurrence of the accident or which may be likely to retard in any way recovery from it?

……

……

……

9. a. Is the patient confined to bed, bedroom, or house by your directions? Yes ☐ No ☐

b. Has patient at any time been confined since the date of the accident? Yes ☐ No ☐

If so give the dates?

……

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10. If still so confined, please state (a) your opinion as to the probable duration of such confinement: (b) probable date of being able to resume some portion of usual business or occupation:

a. …… b. ……

11. Are you prepared to certify that the patient is TOTALLY disabled from attending to any portion of his/her business or occupation?

……

……

(TEMPORARY TOTAL DISABLEMENT occurs when through accidental bodily injury the Patient is immediately and continuously incapacitated for a specific period from attending to business or occupation of any kind).

12. If Patient has been able to attend to a PORTION only of his/her usual business or occupation and if this still continues, please state since when, and also the probable date of recovery

……

……

(TEMPORARY PARTIAL DISABLEMENT arises when the injury does not wholly prevent the Patient from attending to business or when Temporary Total Disablement ceases and he/she can attend to some portion of his/her usual business or occupation but not the whole).

13. If Patient has recovered please state date of recovery ……

GENERAL REMARKS

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I certify that the foregoing statements are correct.

…… ……..

Full name **Qualifications**

…… ……..

Signature **Date**