

## Accidental Disability

The issue of this form does not constitute an admission of liability under the policy. Should this claim be approved the payment will automatically be credited to an account from which your premiums are collected, unless that account is a credit card account, an alternative account number should be provided. In which case if payment is to be credited to an alternative account, please complete the relevant details in Section 1.

Please complete Section 1 and have Section 2 completed by your usual medical attendant, i.e. the doctor you would have consulted most regularly during the last five years.

SECTION 1	
Policy No:	
Policy numbers for any other or previous policies held:	
Initials and surnames of policy holder:	
Full names of claimant:	
Claimants relationship to policyholder:	
Date of birth:	
Full postal address:	
Postal Code:	
Tel Code:	Tel No.:
Fax Code:	Fax No.:
Email address:	
Date of accident:	
Place of accident:	
Describe how the accident occurred:	
State the exact cause and nature of the disability and any important factors connected therewith:	

BANKING DETAILS
Account number:
Account holder's name:
Name of Bank/Building Society:
Type of Account:
Branch:
Branch Code:

DECLARATION AND AUTHORISATION by Policyholder or Legal Representative
I certify that my banking details are correct, failing which Chartis Life South Africa Limited is absolved against all direct losses, liabilities, suits, proceedings, costs, claims, demands, charges and expenses (including all legal and professional fees and disbursements) in respect thereof.
I accept that it is my responsibility to inform Chartis Life South Africa Limited of any changes in my banking details, failing which, Chartis Life South Africa Limited will accept no liability for changes which are not communicated or not communicated timeously. I further declare that the information given is true and complete to the best of my knowledge and belief and authorise any hospital, physician or other person who has attended to me to furnish Chartis Life South Africa Limited or its representatives any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatment, and copies of all hospital records.
I agree that a Photostat copy or facsimile of this authorisation shall be considered as effective and as valid as the original.
Signature
Date

### CERTIFICATE OF USUAL MEDICAL ATTENDANT:

SECTION 2
Full names of patient:
Age:
Date of accident:
Place of accident:
Describe how the accident occurred:
State the exact cause and nature of the disability and any important factors connected therewith:

## SECTION 2 (continued)

Does the present disability relate in any way to previous or existing injuries/conditions or illness? If so, please elaborate:

What is the prognosis:

When were you first consulted for this disability?

Did you attend to the claimant during the course of his/her disability?  
If NO, please state the name and address of the attending physician:

Name

Address:

Postal code:

Tel: Fax:

PLEASE TICK THE DISABILITY SUFFERED AS A RESULT OF THIS ACCIDENT  
LOSS SHALL MEAN:

a) In respect of limbs, the physical separation at or above the wrist or the ankle or the total and irrevocable loss of such a limb.

b) In respect of an eye, the total and irrevocable loss of sight of the eye.

Loss of either one or both hands or one or both feet

Complete and irrevocable loss of sight in one or both eyes

Complete and irrevocable loss of speech

Complete and irrevocable paralysis

Complete and irrevocable insanity

Complete and irrevocable loss of hearing

One ear  Or both

Loss of a whole finger  Loss of fingers

One joint  Two joints  Three joints

Please elaborate or provide a hand sketch:

Loss of one toe

Loss of toes

One joint  Two joints  Three joints

Please elaborate or provide a foot sketch:

Fractured leg or patella with established non-union

Shortening of leg by at least 5cm

Please provide details of any permanent disability not provided for above.

What is the probable date of stabilisation?

In your opinion what percentage permanent disability can be ascribed to this injury alone?

How do you assess his/her motivation and rehabilitation potential?

Please state any information not already mentioned, which might be relevant to the assessment of this permanent disability claim?

## DETAILS OF MEDICAL ATTENDANT

Signature of medical attendant:

Name in block letters:

Date:

Tel Code: Tel No:

Postal address: Postal Code: