CHARTIS

# Group Personal Accident Claim Form

Please print - Do not write

Chartis, 10 Queens Road, Parktown, Johannesburg, 2193
P.O. Box 31983, Braamfontein, 2017
Tel: +27 11 551-8511 | Fax: +27 11 551-8298
www.chartisinsurance.com

**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 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 Chartis South Africa Limited. 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 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 | | | | | | | | | |
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## 2. DEATH CLAIM

| Date of death | D | D | M | M | Y | Y | Place of death |
|---|---|---|---|---|---|---|---|
| State the exact cause of death and any important factors connected therewith | | | | | | | |
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Insurance Fraudline
0860 002526
insurance@fraudline.co.za

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## 1. GENERAL

| Name of insured group | | |
|---|---|---|
| Name of subsidiary (if applicable) | Policy number: | |
| Names and surname of insured person | | |
| Date of birth: | Occupation | |
| Date of accident: | Time: | Place: |
| Give a detailed description of how the accident occurred | | |
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## 2. DEATH CLAIM

| Date of death: | Place of death |
|---|---|
| State the exact cause of death and any important factors connected therewith | |
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**THE FOLLOWING DOCUMENTS SHOULD BE PROVIDED AS IT BECOMES 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 |
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| Please state the name, telephone number and address of the attending doctor. |

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## 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. |
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| Stipulate the insured person's weekly/monthly earnings |
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| 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 |
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## 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

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## 5. CERTIFICATE FROM USUAL MEDICAL ATTENDANT

| Full names and surname of patient | |
|---|---|
| Describe how the accident occurred | |
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| | |
| Date of accident | Place of accident |
| Please state the exact cause and nature of the disability and any important factors connected therewith | |
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| Does the present disability relate in any way to previous injuries or pre-existing conditions or illnesses YES ☐ NO ☐ | |
| If YES, please elaborate | |
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| | |
| 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. | |
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| | |
| | |
| Signature | Full names |
| Postal address | |
| | Postal code |
| Telephone number | |

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