

## Voluntary Employee Benefits Claim Form

NOTES:

1. For all claims, please complete Section 1 & 2
2. Please provide a copy of your latest salary advice and application form.
3. All accidents that could lead to a claim must be notified to us within 30 days of the accident.

TYPE OF CLAIM:

- Accidental death  
 Permanent disability  
 Hospitalisation  
 Temporary total disability  
 Serious Illness

### SECTION 1

#### POLICYHOLDER'S DETAILS

Company name	
Policyholder	
The Insured Person	
Date of Birth	
Units of Cover – Individual <input type="checkbox"/>	Family <input type="checkbox"/>
Relationship to Policyholder	
Occupation	
Postal address	
Code	
E-mail address	
Tel no.	Fax no

#### BANKING DETAILS

Account number
Account Holder's name
Name of bank/building society
Type of account
Branch name
Branch code

#### DECLARATION AND AUTHORISATION

##### *By Policyholder or Legal Representative*

I 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 to 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 or medical records. I agree that a photostatic copy of this authorisation shall be considered as effective and as valid as the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## SECTION 2 – DETAILS OF ACCIDENT

Date of accident	Time	am/pm
Place		
Give full details of how the accident occurred?		
State, as fully as possible, what injuries were suffered		
Name and Address of usual doctor		
Tel/Fax of usual Doctor		

## SECTION 3 - ACCIDENTAL DEATH

Full names and surname of the deceased	
Date of birth	Date of death
Please state the exact cause of death.	

## PLEASE PROVIDE THE FOLLOWING DOCUMENTS:

An original certified copy of the death certificate.

The Post Mortem report.

The full inquest report, including all witness statements pertaining thereto.

The police accident report, if death was due to motor accident.

The police reference number if death was the subject of a criminal investigation.

Copies of any newspaper clippings or eye witness statements that may be available.

In the event of the deceased having been hospitalised prior to death, please attach a copy of the relevant hospital account or have SECTION 4 completed by hospital.

### SECTION 4 – HOSPITALISATION

**THIS IS TO BE FULLY COMPLETED BY THE RELEVANT HOSPITAL AUTHORITY. THE INSURED PERSON MUST HAVE BEEN HOSPITALISED FOR AT LEAST 24 HOURS. PLEASE PROVIDE A COPY OF YOUR HOSPITAL ACCOUNT.**

Patient	
Reason for hospitalisation	
Hospitalisation period	
Admission date	Time
Discharge date	Time
Ambulance transportation	Yes <input type="checkbox"/> No <input type="checkbox"/> (tick applicable box and attach the original account)
Signed	Date
Name	Capacity
Hospital Stamp	

### SECTION 5 – PERMANENT DISABILITY

**THIS IS TO BE FULLY COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER WHERE A PERMANENT DISABILITY COULD RESULT.**

Doctor's name	
Postal address	
	Code
Tel no.	Fax no.
Patient's name	
Age/Date of birth	
1. When did the accident occur?	
2. Please give details	
3. What injuries were sustained?	
Under the terms and conditions of this policy, it is necessary to evaluate the level of the permanent disability solely as a result of the accident.	100% <input type="checkbox"/> 75% <input type="checkbox"/> 50% <input type="checkbox"/> 25% <input type="checkbox"/>
If you feel that a different percentage is more appropriate, please state	
How long have you been treating the patient prior to the accident?	
If any operations were performed, please give details:	
Has the condition now stabilised?	
If no, what is the approximate date of stabilisation?	

### DECLARATION

I certify that my answers to questions in SECTION 4 and SECTION 5 are true and complete to the best of my knowledge and belief.

Signature \_\_\_\_\_ Date \_\_\_\_\_

