INJURY / ILLNESS CLAIM FORM

econorisk

Telephone No. 011 045 8555 **Fax No. 086 558 0080** **Email: claims@econorisk.co.za**
Click on the above link to email our claims consultants

Insurer:	Policy No.:	VAT Reg No.:

Insured

Name and Surname:

Address:	Age:
	Occupation / Business:
Code:	Phone No.:

Insured Person

Name & Surname:

Address:	Age:
	Occupation / Business:
Code:	Phone No.:

Relationship of Insured Person to the Insured

If employee, give annual earnings defined in the policy

If other, specify relationship

Injury / Illness

When did the accident occur / illness commence? Time: Date: day/month/year

Where did the accident occur / illness commence?

Give full particulars of the accident and nature of injuries or the name of the illness:

Witness

Name and Surname:

Address: Code:

Doctor

Name and Surname of doctor who attended to you:

Address: Code:

Name and Surname of your usual doctor:

Address: Code:

(cont.)

Disablement

Period of temporary total disablement: From: day/month/year To: day/month/year

Period of temporary partial disablement: From: day/month/year To: day/month/year

Given date normal occupation resumed: day/month/year

Has any permanent disablement resulted? Yes ☐ No ☐

If 'YES', specify details:

Other insurances

Give name of any other insurer with whom insured person is insured:

Previous claims

Give details of all claims made against insurers or in terms of the WCA by the insured person.Compensation for Occupational Injuries and Diseases Act No. 150 of 1993

Declaration / Authorisation

I / We declare that the above particulars are true in every respect.

Insured's Signature:	Capacity:

Date: day/month/year

IMPORTANT

I hereby authorise any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorised representative all information with respect to any illness or injury, medical history, consultation, prescriptions or tretment, and copies of all hospital or medical records.

A photostat copy of this authorisation shall be considered as effective and valid as the original.

Insured's Signature:	Date: day/month/year

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