econorisk

CLAIM FORM
INJURY / ILLNESS

Insurer		Policy No.		Vat No.	

INSURED

Full Name			
Address			
		Code	
ID No.		Tel No.	
Occupation / Business			

INJURED PERSON

Full Name			
Address			
		Code	
ID No.		Tel No.	
Occupation / Business			

Relationship of Injured 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	
Where did the accident occur / illness commence?				

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

WITNESS

Witness 1

Full Name			
Tel No.			
Address			
		Code	

DOCTOR

Full name of the attending doctor			
Address			
		Code	
Full name of your usual doctor			
Address			
		Code	

DISABLEMENT

Period of temporary total disablement	From		To	
Period of temporary partial disablement	From		To	
Given date normal occupation resumed				
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

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 treatment, and copies of all hospital or medical records.

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

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

Signature of the Insured			
Capacity		Date (yyyy/mm/dd)	

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