OLDMUTUAL

INJURY/ILLNESS CLAIM FORM

Please print in block letters using black or blue ink.

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AGENT/BROKER

Policy no.

Claim no.

DETAILS OF INSURED

Name

Business

VAT registration no.

Physical address

Day telephone no.

DETAILS OF INSURED PERSON

Name

Surname

Age

Business or occupation

If employee, give annual earnings defined in the policy N$

If other, specify relationship to the insured

DESCRIPTION OF ACCIDENT

When and where did accident occur or illness commence?

Date D D M M Y Y Y Y

Time

Place

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

WITNESSES

Name

Physical address

Telephone

DETAILS OF DOCTOR

Name of doctor who attended to you

Address

Name of your house doctor

Address

DETAILS OF PERSONAL INJURIES

Period of temporary full disability FROM D D M M Y Y Y Y TO D D M M Y Y Y Y

Period of temporary partial disability FROM D D M M Y Y Y Y TO D D M M Y Y Y Y

Give date normal occupation resumed D D M M Y Y Y Y

Has any permanent disability occurred? YES NO

If "YES", please provide full details.

DETAILS OF CLAIMS

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

Give details of all claims made against insurers or in terms of WCA by the insured person.

Is the accident attributable to absence of normal care by the claimant? YES NO

If "YES", please provide full details.

DECLARATION/AUTHORISATION

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

Insured's signature

Capacity

Date D D M M Y Y Y Y

IMPORTANT. I hereby authorise any hospital, physician or other person who has attended or examined me, to furnish 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 photostatic copy of this authorisation shall be considered as effective and valid as the original.

Insured person's signature

MEDICAL CERTIFICATE

MUST BE COMPLETED BY THE DOCTOR CONSULTED

The Patient must obtain, at his own expense, the following certificate from a duly qualified and registered Medical Practitioner.

When the Patient is fully recovered a doctor's certificate to that effect should be forwarded to the Insurers showing the periods of partial and total incapacity.

Name of patient

Height Mass

1. When did you first attend upon the Patient in consequence of the Accident/Illness sustained? D D M M Y Y Y Y

2. Are you still in attendance? YES NO

3. Are you the usual medical attendant of the Patient? YES NO

   If "YES", how long have you known him/her? years

4. What was the cause of the Accident/Illness so far as known?

5. What injuries were sustained?

   (a) Region injured (if a hand or an arm, a foot or a leg, state whether it is the right or the left)

   (b) Are the symptoms from which he/she suffers due to:

   (i) The Accident/Illness alone, or YES NO

   (ii) Are they traceable to any other cause? YES NO

6. Have you any reason to suspect that the Patient was not perfectly sober at the time of the Accident? YES NO

7. Is the Patient now or was he/she at the time of the Accident/Illness subject to or suffering from any illness or disease irrespective of the Accident/Illness for which the benefit is claimed? YES NO

   If "YES", state the nature of same and to what extent the recovery of the Patient may be affected thereby.

8. If you are the usual Medical Attendant of the Patient, are you aware of anything in his/her previous medical history which might have contributed directly or indirectly, to the occurrence of the Accident/Illness or which may be likely to retard in any way recovery from it? YES NO

9. (a) Is Patient confined to bed, bedroom, or house by your directions? YES NO

   (b) Has Patient at any time been so confined since the date of the Accident/Illness? YES NO

   If "YES", give the dates: D D M M Y Y Y Y D D M M Y Y Y Y

10. If still so confined, please state:

    (a) Your opinion as to the probable duration of such confinement;

    (b) Probable date of being able to resume some portion of usual business or occupation. D D M M Y Y Y Y

11. Are you prepared to certify that the Patient is **totally** disabled from attending to any portion of his/her business or occupation? YES NO

    (**Temporary Total Disablement** occurs when through accidental bodily injury or illness, the Patient is immediately and continuously incapacitated for a specific period from attending to business or occupation of any kind.

12. If Patient has been able to attend to a PORTION only of his/her usual business or occupation, and if this still continues, please state since when and also probable date of recovery.

D D M M Y Y Y Y D D M M Y Y Y Y

(**Temporary Total Disablement** arises when the injury or illness does not wholy prevent the Patient from attending to business, or when Temporary Total Disablement ceases and he/she can attend to some portion of his/her usual business or occupation, but not the whole).

13. If Patient has recovered, please state date of recovery.

GENERAL REMARKS

I certify that the aforementioned statements are correct.

Name

Qualifications

Signature

Date D D M M Y Y Y Y

Address