

INJURY / ILLNESS CLAIM FORM ONGEVALLE / SIEKTE EISVORM

INSURER / VERSEKERAAR		POLICY NUMBER POLIS NOMMER		VAT REG NUMBER BTW REG NOMMER	
INSURED / VERSEKERDE	Name and Occupation Naam en Beroep				
	Address and phone number Adres en telefoon nommer				
INSURED PERSON VERSEKERDE PERSOON	Name and age Naam en ouderdom				
	Business or occupation Besigheid of beroep				
RELATIONSHIP OF INSURED PERSON TO THE INSURED VERWANTSKAP VAN BESEERDE PERSOON MET VERSEKERDE	If employee, give annual earnings defined in the policy Indien werknemer, verskaf jaarlikse salaris soos gemeld in die polis				
	If other, specify relationship Indien ander, verskaf verwantskap				
INJURY / ILLNESS	When and where did accident occur or illness commence? Wanneer en waar het ongeluk gebeur of siekte begin?	Date Datum	Time Tyd	Place Plek	
	Give full particulars of the accident and nature of injuries or the name of the illness Gee volle besonderhede van die insident, besering of siekte toestand				
WITNESS	Name and address Naam en adres				
DOCTOR DOKTER	Name and address of attending doctor Naam & adres van dokter wat u behandel				
	Name and address of your usual doctor Naam en adres van u huisdokter				
DISABLEMENT ONGESKIKTHEID	Period of temporary total disablement Tydperk van permanente ongeskiktheid	From Van	To Tot		
	Period of temporary partial disablement Tydperk van tydelike ongeskiktheid	From Van	To Tot		
	Give date normal occupation resumed Datum weer met normale diens begin	Date Datum			
	Has any permanent disablement resulted? Give details. Het enige permanente ongeskiktheid ingetree a.g.v. die insident? Gee details				
OTHER INSURANCES ANDER VERSEKERING	Is there any other insurance covering this Loss / Damage? Is daar enige ander versekering wat hierdie verlies / skade dek?				
PREVIOUS CLAIMS VORIGE EISE	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				
	Verskaf besonderhede van alle eise deur die beseerde ingestel teen die Ongevalle Kommissaris. (Compensation for Occupational Injuries and Diseases Act No. 150 of 1993)				
<p>Hiermee waarborg ek/ons dat alle antwoorde / bewering(e) en of verklaring(s) in hierdie eisvorm deur my of namens my gemaak, waar en juis is en dat geen wesenlike feite wat die risiko mag of kan beïnvloed weerhou is nie. Hierdie en enige ander skriftelike verklaring deur my of namens my gemaak word beskou as bindend en is die basis waarvolgens die eis hanteer sal word tussen my/ons en die genomineerde versekeraar. Ek neem kennis dat hierdie nie 'n waarborg is van aanvaarding of bevestiging van erkenning van die skadeloosstelling in terme van hierdie eis nie.</p> <p>I / we hereby warrant that all the above particulars and statements are true and complete and contains all information known to me affecting the risks under the Sections to be insured. This and any other written statement made by me or on my behalf shall be the basis of and incorporated in the contract between me and the nominated insurance company. I take note that this is not a guarantee or acceptance or confirmation of the indemnification in terms of this claim.</p>					
DECLARATION / AUTHORISATION VERKLARING / MAGTIGING	I / We declare that the above particulars are true in every respect. Ek / Ons verklaar plegtig hiermee dat die voorafgaande inligting waar en korrek is.				
	Insured's Signature Versekerde se handtekening	Capacity Hoedanigheid	Date Datum		
<p>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 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.</p> <p>BELANGRIK ! Hiermee magtig ek enige hospitaal, dokter of enige ander persoon wat teenwoordig was of my ondersoek of behandel het, om aan die versekeraars, of hulle gemagtigde verteenwoordiger, alle inligting met betrekking tot enige siekte, besering, mediese geskiedenis, konsultasie, voorskrifte of behandelings en afskrifte van enige hospitaal of mediese rekords te voorsien. n Fotostatische afdruk van hierdie magtiging sal net so 'n aanvaarbare bewys wees as die oorspronklike dokument.</p>					