Film & Entertainment Underwriters SA (Pty) Ltd

Submit Form

Print Form

Personal Accident Claim Form

A. Broker Details

Broker Name

HP number | Tel

Email

B. Insured

Name of Insured

ID Number | Occupation

Postal Address

Tel | Cell

Email

C. Relationship of Injured Person to Insured

If employee, give annual earnings defined in the policy

If other, specify relationship

D. Illness / Injury

Date of accident / illness | Time of accident / illness

Place of accident / illness

E. Witnesses

Full Name | Tel

Address

Full Name | Tel

Address

F. Doctor

Name of doctor who attended to you

Address Tel

Name of your usual doctor

Address Tel

G. Disablement

Period of temporary total disablement From To

Period of temporary partial disablement From To

Give date normal occupation resumed

Has any permanent disablement resulted? Yes ◯ No ◯ Give details:

H. Other Insurances

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

I. Previous Claims

Give details of all claims made against insurers

J. Declaration

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

IMPORTANT: I/We authorize any hospital, physician, or other person who has attended or examined me, to furnish the Company, or its authorized 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 authorization shall be considered as effective and valid as the original.

Insured Person's signature Date

Medical Certificate (to be completed by the consulting doctor)

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 treat the patient in consequence of the accident/illness sustained?

2. Are you still in attendance? Yes ◯ No ◯

3. Are you the usual medical attendant of the patient, and if so, how long have you known him/her?

4. What was the cause of the accident/illness as 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 they traceable to any other cause?

6. Have you any reason to suspect that the patients was not perfectly sober at the time of the accident?

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? If so, 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?

9.a) Is patient confined to bed, bedroom, or house by your directions?

b) Has patient at any time been so confined since date of the accident/illness? If so, give dates

10. If still confined, please state;

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

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

11. Are you prepared to certify that the patient is TOTALLY disabled from attending to any portion of his/her business or occupation?

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 patients 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 the probable date of recovery

TEMPORARY PARTIAL DISABLEMENT arises when the injury or illness does not wholly prevent the patient from attending to business, or when temporary total disablement ceases, and he/she can attend some portion of his/her usual business or occupation, but not the whole.

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

14. General remarks

DECLARATION

I certify that the afore-going statements are correct.

Name

Qualifications

Address

Signature

Date