

# GROUP PERSONAL ACCIDENT

CLEAR FORM

PRINT FORM

## Claim Form

### INSURED

Name of insured	<input type="text"/>
Policy number	<input type="text"/>
Contact person	<input type="text"/>
Contact phone number	<input type="text"/>
Contact email address	<input type="text"/>

### INCIDENT

Estimate	<input type="text"/>	Injured on duty?	<input type="text"/>
Date & time of incident	<input type="text"/>	Death?	<input type="text"/>
Date & time discovered	<input type="text"/>	Is this incident covered under any other policy of insurance?	<input type="text"/>
Date & time reported	<input type="text"/>		
Place of loss	<input type="text"/>		

### POLICE

Place where reported	<input type="text"/>
Date of reporting	<input type="text"/>
Case number (if reported)	<input type="text"/>

### EMPLOYEE

Name	<input type="text"/>
Contact phone number	<input type="text"/>
Contact email address	<input type="text"/>
Address	<input type="text"/>
Occupation	<input type="text"/>

### TEMPORARY / PERMANENT DISABLEMENT

Expected dates off-duty	<input type="text"/>
Expected percentage of permanent disablement	<input type="text"/>

### Please tick which of the following documents are attached

Doctor's certificate	<input type="checkbox"/>
Confirmation of percentage disablement by doctor	<input type="checkbox"/>
Letter of appointment	<input type="checkbox"/>
First & Final Medical report	<input type="checkbox"/>
Original medical accounts and medical aid statements	<input type="checkbox"/>
Police plan and report on scene of accident	<input type="checkbox"/>

## IN CASE OF DEATH

### Beneficiaries under the policy

Name	<input type="text"/>
Policy number	<input type="text"/>
Contact number	<input type="text"/>
Address	<input type="text"/>

### Documents attached (please tick if attached)

Post Mortem report	<input type="checkbox"/>
Inquest report	<input type="checkbox"/>
Letter of executorship	<input type="checkbox"/>

## DECLARATION

I / we declare that to the best of my / our knowledge the above statements are true. I acknowledge that the information set out above is provided freely so that Western may process my claim and give effect to the terms and conditions contained in the policy wording. I herewith give my consent that Western may use this information, my personal information on record and additional information obtained from other sources in order to determine whether to accept or reject my claim, and take all necessary steps ancillary thereto to give effect hereto. I understand that I may be liable for output VAT in terms of section 8(8) of the VAT Act 89 of 1991.

<input type="text"/>	<input type="text"/>	<input type="text"/>
Insured's signature	Capacity	Date

#### Cape Town

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#### Gauteng

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