



insurance done right

Johannesburg

Tel: 0861 266 562

Web: www.one.za.com

Address: 54 Maxwell Drive, Woodmead North Office Park, Woodmead 2021

INJURY/ILLNESS CLAIM FORM

Policy number	
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DETAILS:

Insured person			
ID Number		E-mail Address	
Tel No (H)		Tel No (W)	
Fax Number		Cell Number	
Residential Address			Code
Business or Occupation		VAT Number	

RELATIONSHIP OF INSURED PERSON TO INSURED:

If employee give annual earnings defined in the policy	
If other, specify relationship	

INJURY/ILLNESS:

When and where did accident occur or illness commence?	Place			
		Time		Date
Give full particulars of the accident and nature of injuries or the name of the illness				

WITNESS:

Witness Name			
Residential Address			Code

DOCTOR:

Name of doctor who attended you	
Address of doctor who attended you	
Name of your usual doctor	
Address of your usual doctor	

DISABLEMENT:

Period of temporary total disablement				
Period of temporary partial disablement				
Give date normal occupation resumed				
Has any permanent disablement resulted?	Yes		No	
If so give 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 WCA by the insured person	

DECLARATION / AUTHORIZATION

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

IMPORTANT

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

Signed at: _____ Date: _____

Full Name: _____

Signature