# Family Personal Accident Plan – Claim Form

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| **This form is required in order to assess a potential Claim under a Policy of Insurance. Issue and completion of this form does not in any way imply, construe, or admit liability by the Insurer. Only a fully completed and signed claim form can receive our further consideration. All claims to reported to :**  **Telephone : (011) 731 3693**  **E-Mail :** [**smanga@sha.co.za**](mailto:smanga@sha.co.za)  **Postal : PO Box 55347, Northlands, 2116**  ***All Claims must be notified as soon as possible, but within 180 days from the date of the injury. Failure to do so may result in the Claim being declined for Late Notification*** |

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| SECTION 1 - General |

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| **Name of Insured / Main Member** |  |
| **Name of Claimant** |  |
| **ID Number** |  |
| **Date, time & place of Accident** |  |
| **Was this an injury that occurred during working hours/activities?** |  |
| **SAPS & OAR case number (if applicable)** |  |
| **Give a detailed description of how the Accident occurred** |  |

**The following documentation must be provided for this Claim to be considered: -**

**NOTE: It is not necessary to have all these documents when submitting the completed Claim Form. These documents can be forwarded at a later stage to avoid any unnecessary delays.**

1. **Copy of the Claimant’s latest payslip**
2. **Copy of the Claimant’s ID document**
3. **Additional supporting documents per Claim type, as noted per Section below**

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| SECTION 2 – Accidental Death Claim |

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| **Date & Place of Death** |  |
| **State the exact cause of Death and any important factors connected therewith** |  |

**The following documentation must be provided for this Claim to be considered: -**

**NOTE: It is not necessary to have all these documents when submitting the completed Claim Form. These documents can be forwarded at a later stage to avoid any unnecessary delays.**

1. **Death Certificate**
2. **Post Mortem Report**
3. **Employer’s Report of the Incident (if Injury on Duty)**
4. **Officer’s Accident Report (Traffic Collision Report) if the Death was due to a Motor Vehicle Accident**
5. **Police Reference number if Death is the subject of a criminal investigation**
6. **Copies of any newspaper clipping or eye witness statements that may be available**
7. **In the event of the Bereavement Benefit Claim (if applicable), only the Death Certificate in addition to the Claim Form will be required**

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| SECTION 3 – Permanent Disability Claim |

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| **Give full details of the Injuries sustained by the claimant** |  |
| **Name of the attending Doctor** |  |
| **Practice Number** |  |
| **Telephone Number** |  |
| **Address** |  |
| **Has any Permanent Disablement resulted from this Accident? If yes, please give details** |  |

**The following documentation must be provided for this Claim to be considered: -**

**NOTE: It is not necessary to have all these documents when submitting the completed Claim Form. These documents can be forwarded at a later stage to avoid any unnecessary delays.**

1. **Employer’s Report of the Incident (if Injury on Duty)**
2. **Officer’s Accident Report (Traffic Collision Report) if the Injury was due to a motor vehicle accident**
3. **Police Reference number if Injury is the subject of a criminal investigation**
4. **Copies of any newspaper clipping or eye witness statements that may be available**
5. **Copies of on-going Medical Reports detailing the Injury, diagnosis and recovery prognosis**

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| SECTION 4 – TTD/Income Replacement (if applicable, and ONLY applicable to the Insured /Main Member/policy Holder) |

**The following documentation must be provided for this Claim to be considered: -**

**NOTE: It is not necessary to have all these documents when submitting the completed Claim Form. These documents can be forwarded at a later stage to avoid any unnecessary delays.**

1. **Employers Report of the incident (if Injury on Duty)**
2. **Officer’s Accident Report (Traffic Collision Report) if the Injury was due to a Motor Vehicle Accident**
3. **Police Reference number if Injury is the subject of a criminal investigation**
4. **Copies of any newspaper clipping or eye witness statements that may be available**
5. **Copies of Medical Reports detailing the Injury, diagnosis and recovery prognosis**

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| SECTION 5 – Non-Medical Expense Cover as a result of Hospitalisation Benefit |

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| **An original Hospital Account proving admission into hospital and discharge dates is required when claiming under this section**  As this is an Insurance Policy, an accident which results in you being admitted to a Hospital, can be claimed under the Policy. Benefits will only become payable AFTER 48 consecutive hours of being admitted to Hospital as an in-patient – note that Casualty or Emergency Room treatments will not be payable under this Benefit. This Benefit will be applicable to a maximum of 10 consecutive days Hospitalised, and will be calculated from day 1 in hospital (subject to the patient being admitted for a minimum of 48 consecutive hours). This is known as a Franchise.  All that will be required in order to finalise your claim is the fully completed claim form and a copy of your original Hospital Account (the first page will be sufficient as it provides details of the admission date and discharge date, the patient who was admitted as well as the reason for admission).  **REMEMBER: This is a 24 hour accidental injury policy, so illness related admissions will not be covered.** |

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| AUTHORISATION |

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| **Authorisation to be completed by the Claimant or his/her legal representation.**  **I hereby authorise any hospital, physician or any other person who treated me, to furnish the Insurer or the legal representatives with all information with regard to any Injury, sickness medical history, consultations, prescription or treatment including copies of all my hospital or medical reports. I agree that a photostat / fax copy of this authorisation shall be accepted as the original. I declare that the answers given by me in this claim form are true in every respect.**  **I agree to co-operate where additional reports are called for by the Insurer, which may require me to attend further medical assessments with Insurer appointed Medical Professionals. I understand that any costs associated with this Insurer request will be for the Insurers cost.** | |
| **Signature of the Claimant or his/her legal representative** |  |
| **Date** |  |

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| **Declaration by Insured / Policy Holder.**  **I hereby warrant the truth of all particulars on this form in every respect and declare that all conditions of this Insurance have been complied with** | |
| **Signature of the Insured / Main Member or his/her legal representative** |  |
| **Date** |  |

**I/We acknowledge that the information submitted in this proposal form may be protected by data protection legislation, such as the Protection of Personal Information Act 2013 (POPI) and accordingly hereby consent to the use of such information by SHA Risk Specialists a division of Santam Ltd (the Insurer) to:-**

1. **Verify the information disclosed herein against any other source;**
2. **Communicate with you directly should you request us to and in accordance with relevant regulatory requirements;**
3. **Compile non-personal statistical information to assist in assessing similar risks;**
4. **Assess the risk to be underwritten and, if a Policy of Insurance is issued pursuant to and based upon such information, that said information may be used at a later stage to assess any future claims that I/We may have against any such Insurances issued by SHA Risk Specialists a division of Santam Ltd;**
5. **Transmit your personal information to any affiliate, subsidiary or re-insurer so that we can provide insurance services to you and to enable us to further our legitimate interests including statistical analysis, reinsurance and credit control;**
6. **Transmit your personal information to any third party service provider who has a need to know such information in order to perform functions relating to your Policy;**
7. **Share your personal information on the SAIA policyholder database for the combatting of insurance fraud and improved evaluation of risks.**

**I/We further acknowledge that this consent clause will remain in force even if your Policy is cancelled or lapses.**

**Due to SHA’s FSCA Licensing status and in light of the requirements set out in the Protection of Personal Information Act 2013 (POPI) we are not strictly speaking allowed to contact you directly and would generally communicate with you via your broker. However there may be instances where we may need to contact you directly in order to advise you of important matters relating to your Policy. Therefore please indicate below how you prefer to be contacted in the unlikely that we should need to contact you directly.**

**SMS \_\_\_\_\_\_ Email \_\_\_\_\_\_ Phone \_\_\_\_\_\_ Mobile \_\_\_\_\_\_ Post \_\_\_\_\_\_\_**

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| MEDICAL CERTIFICATE |
| **This Certificate is to be completed by the Medical Practitioner consulted**  **The Claimant must obtain, at his/her own expenses, the following Certificate from a duly qualified and registered Medical Practitioner who treated him/her for his/her injuries. When the Claimant is fully recovered, a Doctor’s Certificate to that effect must be forwarded to the Insurer showing the periods of partial and total incapacity** |
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| **Full name of Patient** |  |
| **When were you first consulted by the Claimant in connection with his/her injuries** |  |
| **Are you still in attendance** |  |
| **What was the cause of the Accident so far as known** |  |
| **What injuries were sustained** |  |
| **Please state the exact cause and nature of the Disability and any important factors connected therewith** |  |
| **Does the present Disability relate in any way to previous injuries or pre-existing conditions or illness** |  |
| **If yes, please explain** |  |
| **Is the Patient now or was he/she at the time of the accident subject to or suffering from any illness or disease irrespective of the accident for which the benefit is claimed?** |  |
| **If so, state the nature of it, and to what extent the recovery of the patient may be effected thereby** |  |
| **Is the patient temporarily or permanently Disabled from attending to any portion of his/her usual business or occupation** |  |
| **If yes, please explain** |  |
| **Please state any information not already mentioned which is relevant to the assessment of any Permanent Disability arising from the accident** |  |
| **If the Patient has fully recovered, please state the date of recovery** |  |

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| DECLARATION BY MEDICAL PRACTITIONER |

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| **I hereby certify that the above statements are true in every respect** |

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| **Name:** |  |
| **Qualifications:** |  |
| **Signature:** |  |
| **Date:** |  |
| **Address:** |  |
| **Telephone Number** |  |
| **Practice Number:** |  |