SHA
risk specialists

GROUP PERSONAL ACCIDENT / STATED BENEFITS INSURANCE **CLAIM FORM**

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:

Smangaliso Mbatha
Telephone: (011) 731 3638
Email: smanga@sha.co.za
Postal address: PO Box 55347, Northlands, 2116
Physical address: The Pavilion Building, Wanderers Office Park, 52 Corlett Drive, Illovo, 2196

IMPORTANT – All claims must be notified as soon as possible, but within at least 180 days from the date of the injury. Failure to do so may result in the Claim being declined due to late notification.

SECTION 1: GENERAL

Name of insured	
Name of claimant	
ID number	
Email address	
Contact number	
Date, time and place of the accident	
Is this an injury during working hours / activities?	
SAPS & OAR case number (if applicable)	
Give a detailed description of how the accident occurred	

The following general documentation must be provided for this claim to be considered:

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

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.

SECTION 2: DEATH CLAIM (IF APPLICABLE)

Date and place of death	
State the exact cause of death and any important factors connected therewith.	

The following documentation must be provided for this death claim to be considered:

1. Death certificate
2. Post mortem report
3. Employers 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

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.

SECTION 3: PERMANENT DISABILITY CLAIM

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? ☐ NO ☐ YES

If YES, please give details

The following documentation must be provided for this claim to be considered:

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 on-going medical reports detailing the injury, diagnosis and recovery prognosis

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.

SECTION 4: TTD / INCOME REPLACEMENT BENEFIT (IF APPLICABLE)

The following documentation must be provided for this death claim to be considered:

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
6. In the event of serious illness, a copy of the medical report detailing the first diagnosis

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.

SECTION 5: NON-MEDICAL EXPENSE COVER AS A RESULT OF HOSPITALISATION BENEFIT (IF APPLICABLE)

An original hospital account proving admission into hospital and discharge dates is required when claiming under this section

SECTION 6: EMERGENCY EXPENSES SHORTFALL BENEFIT (IF APPLICABLE)

Original medical accounts and copies of the relevant medical scheme statements associated with the treatment of Injuries sustained as a result of the accident, are required when claiming under this section. please remember that only medical costs not paid by a registered medical scheme will be considered under this section, which includes medical accounts paid directly from a member's medical scheme savings account. Any costs recoverable from COID and / or RAF will not be paid under this section, but should be referred to accident expert for assistance in recovering these costs.

AUTHORISATION

Authorisation to be completed by the claimant or his / her legal representative, or the parent / legal guardian of a minor child.

- 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.
- I further consent to the Insurer processing my or my minor dependent's personal information (if applicable) provided in relation to this claim, including but not limited to full name and identity number and medical information as is required under the first bullet noted above, for the purposes of the assessment of the claim notified herein. I understand that should such consent not be granted by me, that Insurers will not be able to attend to the assessment of the claim so submitted.
- I understand that certain further information regarding the claim notified may be obtained from other sources such as the South African Police Service or through loss adjustors / legal advisors / investigators in order for the insurer to properly investigate the circumstances giving rise to the claim.

In proceeding with this claim, I wish to request that **all future communication** should be sent to:

☐ Myself (the claimant) directly; OR

☐ My company / employer / minor child's education facility; OR

☐ Both my company / employer / minor child's education facility and myself

I understand that the intermediary / broker will be copied in on all correspondence.

Signature of the claimant or his / her legal representative, or the parent / legal guardian of a minor claimant	
Date	
Place	

DECLARATION BY INSURED / CLAIMANT / LEGAL GUARDIAN OF MINOR CHILD

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.

I / We acknowledge that the information submitted in this claim 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 / Santam Ltd (the Insurer) to:-

a. Verify the information disclosed herein against any other source;

b. Communicate with me directly should the Insurer be required to do so or should I / We request the insurer to do so and in accordance with relevant regulatory requirements;

c. Properly and appropriately assess the claim submitted by me herein in the legitimate interests of the Insurer and / or the claimant / insured employee / student;

d. Compile non-personal statistical information to assist in assessing similar risks;

e. Transmit my / our personal information to any affiliate, subsidiary or re-insurer so that the Insurer can provide insurance services to me/us and to enable the Insurer to further its legitimate interests including statistical analysis, reinsurance and credit control;

f. Transmit my / our personal information to any third party service provider who has a need to know such information in order to perform functions relating to my Policy;

g. Share my / our personal information on the SAIA policyholder database for the combatting of insurance fraud and improved evaluation of risks.

I / We acknowledge that this consent clause will remain in force even if my / our policy is cancelled or lapses.

I further understand that I have the right to object, on reasonable grounds, to the processing of any personal information provided to the insurer but that this may mean that the insurer will not be able to complete the assessment of the claim in question.

Signature	
Date	
Capacity	
Company stamp	

MEDICAL CERTIFICATE

This Certificate is to be completed by the doctor 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.

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 ☐ NO ☐ YES

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? ☐ NO ☐ YES

If YES, 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 ☐ NO ☐ YES

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

DECLARATION

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

Name

Qualifications

Signature

Date

Address

Telephone number

Practice number

SAVE