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Consultants & Acceptances (Pty) Ltd

INJURY/ILLNESS CLAIM FORM

Broker details

Broker name		Claim Number: Jhb	
Claim Number: Jhb		Certificate Number	

The Insured

Name of business					
Address and code					
Postal and code					
Work tel		Cell		Fax	
Email					
Occupation of business					

Insured person

Full name and surname		ID		Age	
Occupation		Relationship to insured			
Work tel		Cell		Fax	
Email					
If employee give annual earnings defined in the policy					

Details of injury/illness

Where did injury/illness occur?		Date	

Give full particulars of the accident and nature of injuries or the name of the illness

Witness

Full name and surname		ID		Age	
Address and code					
Work tel		Cell		Fax	
Email					

Doctors/Specialists

Doctor/specialist who attended you

Full name and surname of doctor				Practice number	
Work address					
Work tel		Cell		Fax	

Your usual doctor

Full name and surname of doctor				Practice number	
Work address					
Work tel		Cell		Fax	

Disablement

Temporary total displacement from (date)		to (date)	
Temporary partial displacement from (date)		to (date)	
Date normal occupation will resume (date)			

Has any permanent disablement resulted? Yes ☐ No ☐

Give details

Declaration

I/We warrant the truth of the answers to the above questions and I/we declare that no information has been withheld and that the amount claimed represents my/our loss arising from above stated occurrence.

Signed at	Date
Signature of the insured	

Please note: The issue of this form is not an admission of Liability.