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
E-Mail : smanga@sha.co.za
Postal : PO Box 55347, Northlands, 2116

Jacquiline Chemaly
Telephone : (011) 731 3722
E-Mail : jacquiline@sha.co.za
Postal : PO Box 55347, Northlands, 2116

Section 1: General

Name of Insured	
Name of Claimant	
ID Number	
Date, time & place of Accident	
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 ID document
2. Additional supporting documents per Claim type, as noted per Section below

Section 2: Death Claim (if applicable)

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. Report from Director and/or Referee (Injury on Duty)
3. Officer's Accident Report (Traffic Collision Report) if the Death was due to a Motor Vehicle Accident
4. In the event of the Bereavement Benefit Claim (if applicable), only the Death Certificate in addition to the Claim Form will be required

Section 6: Emergency Expenses

Original Medical Accounts and copies of the relevant Medical Scheme statements associated with the treatment of Injuries sustained as a result of the Injury, are required when claiming under this section. Please remember that the Emergency Expenses benefit is a benefit payable to indemnify a financial loss to the Insured

AUTHORISATION

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.

Signature of the Claimant or his/her legal representative	
Date	
Place	

Declaration by Insured

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:	
Date:	
Capacity	
Company Stamp	

MEDICAL CERTIFICATE

This Report is to be completed by the Doctor consulted.

Original Doctors Report associated with the treatment of injuries sustained as a result of the injury is required when claiming under this section. Please remember that the Emergency benefit is a benefit payable to indemnify a financial loss to the insured.

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	
If yes, please explain.	
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:	