Abelard
UNDERWRITING AGENCY

PERSONAL ACCIDENT INITIAL CLAIMS NOTIFICATION FORM

A – Details of the Policy						
Insurer:	Abelard Underwriting Agency on behalf of Guardrisk Insurance Company Limited					
Policy Number:						
Insured:						
B – Details of the Insured Person						
Name:			Occupation:			
Address:						
Contact Numbers:	Tel:		Fax:		Cell:	
Identity Number:			Date of Birth:			
C – Details of the Accident						
Details:	Date:		Time:		Place:	
Provide a detailed description of how the Accident happened:						
D – Death Claim (Complete if applicable)						
Date of Death:			Place of Death:			
State the cause of death and any other important factors connected therewith:						

The following information/documentation must be provided as and when it becomes available:-	
A	Certified copies of the abridged and final Death certificates
B	A certified copy of the post mortem report
C	A certified copy of the full inquest report including all witness statements pertaining thereto
D	If death was as a result of a motor vehicle accident, the police accident report
E	If the death is the subject of a criminal investigation, SAPS Case No and relevant police station

E – Disability Claim (Complete if applicable)

Please provide full details of the injuries sustained by the Insured Person			
Details of the attending doctor:			
Name:		Tel:	
Address:		Fax:	
Period for which Temporary Total Disability compensation will apply(s):			
From:		To:	
Date of resumption of usual occupation:			

Is the Insured Person still receiving treatment for injuries sustained:	Yes	No
If yes, please provide details		
Please provide details of any Permanent Disability suffered as a result of the accident		

The following declaration must be signed by the Insured Person or their legal representative:

I hereby authorize any hospital, physician or other person who has treated me to furnish the Underwriters or their representatives with all the information with regard to any injury, sickness, medical history, consultations, prescriptions or treatment including copies of all my hospital or medical records.

I agree that a photo/fax copy of this authorization shall be accepted as the original

_____ _____

Signature of Insured Person / legal representative — Date

_____ _____

Capacity — Place

F – Employment Information and Employer Declaration

Name of Employer:		
Occupation and duties of the Insured Person		
Was the Insured Person employed under a contract of employment at the time of the accident?	Yes	No
Was the Insured Person employed as a contractor at the time of the accident?	Yes	No

F – Employment Information and Employer Declaration – Continued

Is there any form of recovery due from COIDA in respect of Medical Expenses or Temporary Total Disability?	Yes	No

If yes, please provide details	

The following declaration must be signed by an authorised signatory of the employer:

I/We hereby warrant the foregoing particulars to be correct, true and accurate in every respect.
I/We accept and understand that any false or incorrect information could severely prejudice the validity of the claim.
I/We hereby declare that we have complied with the conditions of the insurance

_____ _____

Authorised Signatory Date

_____ _____

Name (in block letters) Place

_____

Capacity

Company Stamp:

G – Certificate from usual Medical Attendant			
Name:		Tel:	
Address:		Fax:	
Full Name of patient:			
Description of Accident			
State exact cause and nature of the disability(s):			
Does the present disability relate in any way to previous injuries or pre-existing conditions?		Yes	No
If yes, please provide details			
Details of any other attending doctor:			
Name:		Tel:	
Address:		Fax:	
Date of or probable date of stabilization?			
Please advise, in your opinion, the degree of disability (percentage):			
Please provide any additional information which you feel may be relevant:			

_____ _____

Signature Date