# PERSONAL ACCIDENT INITIAL CLAIMS NOTIFICATION FORM

| **A – Details of the Policy** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Insurer: | Abelard Underwriting Agency on behalf of Regent 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 Attendent | | | |
|---|---|---|---|
| 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