



Injury/Illness Claim Form



Please complete this claim form in BLOCK CAPITALS and send it to your broker or to
Zurich Insurance Company South Africa Limited
 70 Fox Street, Johannesburg, 2001 PO Box 61489, Marshalltown, 2107
 Registration No. 1965/006764/06
 Authorised Financial Services Provider No. 17703

The information that is sought herein is not intended to be an exhaustive list and Zurich accordingly reserves it's right to request any further information it deems appropriate while investigating the claim

Broker/Agent		Policy No.	Claim No.	
Insured	Name and business			
	Address and (day) telephone No.			
Insured person	Name and age			
	Business or occupation			
Relationship of insured person to insured	If employee, give annual earnings defined in the policy			
	If other, specify relationship			
Injury/illness	When and where did accident occur or illness commence	Date	Time	Place
	Provide full particulars of the accident and nature of injuries or the name of the illness			
Pre-existing medical conditions	Provide full details of all pre-existing medical conditions			
Witness	Name and address			
Doctor	Name and address of doctor who attended to you			
	Name and address of your usual doctor			
Disablement	Period of temporary disablement	From	To	
	Period of temporary partial disablement	From	To	
	Provide date normal occupation resumed	Date		
	Has any permanent disablement resulted? Give details			
Other insurances	Provide name of any other insurer with whom insured person is insured			
Previous claims	Provide details of all claims made against insurers or in terms of the WCA by the insured person			
Declaration	I/We declare that the above particulars are true in every respect			
	<p style="text-align: center;">Important</p> <p>I hereby authorise and hospital, physician, or other person who has attended or examined me to furnish to the Company, or it's authorised representative, all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorisation shall be considered as effective and valid as the original</p>			
	Signature of Insured	Capacity	Date	

Medical certificate

Must be completed by the doctor consulted.

The patient must obtain, at his/her expense, the following certificate from a duly qualified and registered medical practitioner.
When the patient is fully recovered a doctor's certificate to that effect should be forwarded to the insurers showing the periods of partial and total incapacity.

	Name of patient	Height	Mass
1	When did you first treat the patient in consequence of the accident/illness sustained?		
2	Are you still in attendance?		
3	Are you the usual medical attendant of the patient, and if so, how long have you known him/her?		
4	What was the cause of the accident/illness so far as known?		
5	What injuries were sustained? (a) region injured (if hand or an arm, a foot, or a leg, state whether it is the right or the left) (b) Are the symptoms from which he/she suffers due to:		
		(i) the accident or illness alone, or	
		(ii) are they traceable to any other cause?	
6	Have you any reason to suspect that the patient was not perfectly sober at the time of the accident?		
7	Is the Patient now, or was he/she at the time of the accident/illness subject to or suffering from any illness or disease irrespective of the accident/illness for which the benefit is claimed? If so state the nature of same, and to what extent the recovery of the patient may be affected thereby.		
8	If you are the usual medical attendant of the patient, are you aware of anything in his/her previous medical history which might have contributed directly or indirectly, to the occurrence of the accident/illness, or which may be likely to retard in any way recovery from it?		
9	(a) Is the patient confined to bed, bedroom, or house by your discretion? (b) Has the patient at any time been so confined since the date of the accident/illness? If so give the dates:		
10	If still so confined, please state	(a) Your opinion as to the probable duration of such confinement;	
		(b) Probable date of being able to resume some portion of usual business or occupation:	
11	Are you prepared to certify that the patient is TOTALLY disabled from attending to any portion of his/her business or occupation?		
12	TEMPORARY TOTAL DISABLEMENT occurs when through accidental bodily injury or illness, the patient is immediately and continuously incapacitated for a specific period from attending to business or occupation of any kind. If patient has been able to attend to a PORTION only of his/her usual business or occupation, and if this still continues, please state since when, and also the probable date of recovery. TEMPORARY PARTIAL DISABLEMENT arises when the injury or illness does not wholly prevent the patient from attending to business, or when temporary total disablement ceases, and he/she can attend to some portion of his/her usual business occupation but not the whole.		
13	If patient has recovered please state date of recovery		
	General Remarks		
Pre-existing medical conditions	How is the current injury/illness aggravated by pre-existing medical conditions		
Declaration	I/We declare the above particulars are true in every respect. Name _____ Qualifications _____ Signature _____ Date _____ Address _____ Signature of Insured _____ Capacity _____ Date _____		