Claim nr: _____ **CareCard nr:** _____ **Basket:** _____

GROUP PERSONAL ACCIDENT 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 be notified to :

Telephone : (033) 342 8503
E-Mail : admin@carecard.co.za
Postal : PO Box 11939, Dorpspruit, 3206

This claim form with required documentation sent to:

E-Mail : janet@care4all.co.za
Postal : PO Box 11939, Dorpspruit, 3206

Once claim form and required documentation are submitted, the Broker can be contacted for progress on the claim:

PSG Insure Potchefstroom
Corne Ackerman
Telephone : (018) 293 1110
Cell : 079 495 8880
E-Mail : Corne.Ackerman@psg.co.za

Section 1: General:

Name of Insured	
ID Number of Insured	
Name of Claimant / Main Member	
ID Number of Claimant / Main Member	
Medical Scheme Details	
Date, time & place of Accident	
Is this an Injury during working or school hours/activities? (Applicable with Diamond Basket only)	
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: APPLICABLE: NO ☐ **Yes** ☐ **If yes, please complete and supply the following:**

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. Post Mortem Report
3. Employers Report of the Incident (if Injury on Duty)
4. Officer's Accident Report (Traffic Collision Report) if the Death was due to a Motor Vehicle Accident
5. Police Reference number if Death is the subject of a criminal investigation
6. Copies of any newspaper clipping or eye witness statements that may be available
7. In the event of the Bereavement Benefit Claim (if applicable), only the Death Certificate in addition to the Claim Form will be required

Section 3: Permanent Disability Claim: APPLICABLE: NO ☐ **Yes** ☐ **If yes, please complete and supply the following:**

Give full details of the Injuries sustained by the claimant	
Name of the attending Doctor	
Practice Number	
Telephone Number	
Address	
Has any Permanent Disablement resulted from this Accident? If yes, please give details:	

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. Employers Report of the Incident (if Injury on Duty)
2. Officer's Accident Report (Traffic Collision Report) if the Injury was due to a motor vehicle accident
3. Police Reference number if Injury is the subject of a criminal investigation
4. Copies of any newspaper clipping or eye witness statements that may be available
5. Copies of on-going Medical Reports detailing the Injury, diagnosis and recovery prognosis

Section 4: Hospitalisation Benefit: APPLICABLE: NO ☐ **Yes** ☐ **If yes, please supply the following:**

An original Hospital Account proving admission into hospital and discharge dates is required when claiming under this section

Section 5: Medical Expenses Benefit: APPLICABLE: NO ☐ **Yes** ☐ **If yes, please supply the following:**

Original Medical Accounts and copies of the relevant Medical Scheme statements associated with the treatment of Injuries sustained as a result of the Accident, are required when claiming under this section. Please remember that only Medical costs not paid by a registered Medical Scheme will be considered under this section, which includes Medical Accounts paid directly from a Member's Medical Scheme Savings account.

Is this the complete claim with all final documentation?	
If not, what is outstanding and the reason/s?	

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 Person (if under aged to be signed by Claimant / Main Member)
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	

MEDICAL CERTIFICATE

This Certificate is to be completed by the Doctor consulted

The Claimant must obtain, at his/her own expenses, the following Certificate from a duly qualified and registered Medical Practitioner who treated him/her for his/her injuries. When the Claimant is fully recovered, a Doctor's Certificate to that effect must be forwarded to the Insurer showing the periods of partial and total incapacity.

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	
Please state the exact cause and nature of the Disability and any important factors connected therewith	
Does the present Disability relate in any way to previous injuries or pre-existing conditions or illness	
If yes, please explain	
Is the Patient now or was he/she at the time of the accident subject to or suffering from any illness or disease irrespective of the accident for which the benefit is claimed?	
If so, state the nature of it, and to what extent the recovery of the patient may be effected	
Is the patient temporarily or permanently Disabled from attending to any portion of his/her usual business or occupation	
If yes, please explain.	
Please state any information not already mentioned which is relevant to the assessment of any Permanent Disability arising from the accident	
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:	

SUMMARY OF DOCUMENTATION ATTACHED

NR	DESCRIPTION	AMOUNT CLAIMED
	TOTAL AMOUNT CLAIMED	