

ACCIDENTAL INJURY FORM (PERSONAL DECLARATION)

To allow us to make an assessment of your claim under the policy, please answer all the relevant questions in full. Please send this form together with all reports directly to: The Claims Specialist, at the above address, or fax it to 086 676 2565.

1. CLAIMANT DETAILS

Full Name

ID Number

Address
 Postal Code

Telephone Home Work Cellphone

Occupation

My last day actively at work and being capable of performing my job was:

The date I will return to work or did return to work is:

2. MEDICAL DETAILS

Details of injury

I am of the opinion I can no longer work because

I am currently taking the following medication (Include any pain medication if applicable)

Do you suffer from any conditions that warrant regular medication and follow up?

How has it affected your activities of daily living?
 Eg. Bathing, dressing, mobility, etc

Were you hospitalized ? Yes / No
 If yes, please provide the Hospital name and dates of admission and discharge
 (Attached detailed hospital account)

Hospital name:	
Date of admission:	
Date of Discharge:	

3. DOCTOR DETAILS

	Family Doctor (GP)	Specialist (1)	Specialist (2)	Other
Name				
Speciality				
Address				
Telephone Number				
Date/s consulted				

4. MEDICAL INSURANCE AND OTHER INSURANCE

Name of Medical scheme

Membership number

Are you claiming against any other insurance policy ? If yes, please provide details:

Name of Company

Policy Number

5. BANK DETAILS

Full names in which account operates

Type of account: Current Savings Transmission

Bank Name

Branch

Bank account number

Branch code

6. COMMENT

This space is for additional information you wish to give MS Life that may assist with the assessment and processing of this claim

Please submit any medical reports, x-ray reports and laboratory reports that you might have in your possession as supporting documentation for this claim.

7. DECLARATION

I hereby declare that all information supplied on this form is true and correct and that no material information has been withheld. I hereby authorise any medical practitioner, hospital or other person to furnish MS Life with any information relating to my injury or illness. I hereby consent to any information pertaining to my medical aid membership being disclosed to MS Life for the purposes of assessing and managing the claim. I also hereby authorise MS Life to release the aforementioned information to other parties involved in the assessment and management of the claim.

Employee Name

Signature

Witness Name

Signature

Date