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Injury/Illness Claim Form

Policyholder Details

Insurer	Mutual and Federal Risk Financing Ltd				
Insured			Policy Number		
Telephone	Home		Work		Cell	

Broker Details

Broker Name						
Contact	Tel no		Fax		E-mail	

Details of Injury/Illness

If employee give annual earnings			
If other, specify relationship			
Name		Address	

Telephone	Home		Work		Cell	
Date of Illness			Time of Accident or Illness			

Give full particulars of the accident and nature of injuries or the name of the illness

Witnesses Details

Name		Address	

Telephone	Home		Work		Cell	

Doctor Details

Name		Address	

Telephone	Home		Work		Cell	

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Disablement

Period of temporary total displacement	From	
Period of temporary partial disablement	From	
Give date normal occupation resumed		

Has any permanent disablement resulted	Yes		No	
If so give details				

Other Insurance Details

If other insurer please give details

Name			Address			
Telephone	Home		Work		Cell	

Details of Injury/Illness

Give details of all claims made against insurers or in terms of the WCA by the insured person. Compensation for Occupational in juries and Diseases Act No. 150 of 1993

Name			Address			
Telephone	Home		Work		Cell	

Your Responsibilty

Group Personal Accident

1. Completed personal accident claim form.
2. First medical / progress report and final report.
3. Gross annual earnings.
4. Medical bills.
5. Confirmation of medical aid.
6. Confirmation of report to workers compensation (if applicable)
7. Progress from Workman’s compensation (if applicable)

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Disclaimer

You are responsible for giving us true and complete information relevant to this claim. You hereby confirm that your loss or damage occurred during the period of insurance.

Signed at: ____________________ Signature: ____________________

Name and surname of signatory: ____________________

Designation: ____________________ Date: ____________________

Ibiliti Underwriting Managers

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