Minet

AON | Global Network Correspondent

GROUP PERSONAL ACCIDENT CLAIM FORM

Minet Namibia Insurance Brokers (Pty) Ltd
Risk Consultants and Insurance Brokers

THIS FORM IS REQUIRED IN ORDER TO ACCESS A PENDING 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 CLAIM FORM CAN RECEIVE CONSIDERATION BY THE INSURER.
Sections 1,2,3 and 4 are to be completed by the Insured Group or the Subsidiary claiming and Section 5 by the medical attendant. Please note that payment for any expenses incurred in the completion of this form is the responsibility of the claimant.

Also note that the insurer requires the original medical accounts to support all claims for reimbursement of medical expenses. In the event that the claim is in respect of the shortfall after any medical aid payments then a copy of the statement from the Medical Aid Society is required.

1. General

Name of insured group _____

Name of subsidiary (if applicable) _____ Policy number _____

Names and surname of insured person _____

Date of birth _____ Occupation _____

Date of accident _____ Time _____ Place _____

Give a detailed description of how the accident occurred _____

_____

_____

_____

_____

_____

_____

2. Death Claim

Date of Death _____ Place of death _____

State the exact cause of death and any important factors connected therewith _____

_____

_____

THE FOLLOWING DOCUMENTATION SHOULD BE PROVIDED AS IT BECOMES AVAILABLE:

1) Certified copies of the abridged and the final death certificate
2) A certified copy of the Port Mortem Report
3) A certified copy of the full Inquest Report including all witness statements pertaining thereto
4) The police accident report if death was due to a motor accident
5) The police station and reference number if death is the subject of a criminal investigation
6) Copies of any newspaper clippings, eye-witness statements or incident reports that may be available

3. Disability Claim

Give full details of the injuries sustained by the insured person _____

_____

_____

_____

Please state the name, telephone number and address of the attending doctor

Name _____ Telephone code/number (____) _____

Address _____

Please state the period during which the insured person was **totally** disabled from attending to his/her usual occupation

From _____ To _____ (Both dates inclusive)

Please state the period during which the insured person was **partially** disabled

From _____ To _____ (Both dates inclusive)

Please state the date upon which he/she resumed his/her usual occupation _____

Is he/she still receiving treatment for his/her injuries | YES | NO | (Tick the applicable box)

If YES, please elaborate _____

_____

_____

Give details of any permanent disability suffered as a result of **this** accident _____

_____

_____

_____

AUTHORIZATION TO BE COMPLETED BY THE INSURED PERSON OR HIS/HER LEGAL REPRESENTATIVE

I hereby authorise any hospital, physician or other person who has treated me to furnish to the insurer or its representatives any and all information with respect to any sickness, injury, medical history, consultations, prescriptions or treatment, and including copies of all my hospital or medical records. I agree that a photostatic copy of this authorisation shall be considered as effective and as valid as the original.
Signature of the insured person or his/her legal representative _____

Date _____ Place _____

4. Employer's Certificate

Full names of employer _____

Names and surname of the insured person _____

Category within which the insured person falls under the policy _____

Was the insured person in your direct employment or in that of a sub-contractor at the time of the accident

_____

State fully the nature of the insured person's occupation and daily duties _____

_____

_____

Stipulate the insured person's weekly/monthly earnings

_____	N$ _____	_____	N$ _____
_____	N$ _____	_____	N$ _____
_____	N$ _____	_____	N$ _____
_____	N$ _____	Total weekly/monthly earnings	N$ _____

Are any medical expenses or compensation payable in terms of any Workman's Compensation Act or by any other insurer

YES	NO

(Tick the applicable box) if YES, give full details _____

_____

_____

DECLARATION BY EMPLOYER

I/We hereby warrant the truth of all the particulars on this form in every respect and declare that the conditions of this insurance have been complied with.

Signature _____ **Name in block letters** _____

Date _____ **Capacity** _____

Company stamp

5. Certificate from usual medical attendant

Full names and surname of patient _____

Describe how the accident occurred _____

_____

Date of accident _____ Place of accident _____

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 illnesses?

YES	NO

If YES, please elaborate _____

_____

What is the prognosis _____

YES	NO

Did any doctor other than you attend to the patient during the course of his/her disability

If YES, please state the name and address of any other attending doctor

Name _____

Address _____

What is the probable date of stabilisation _____

In your opinion what percentage of permanent disability can be ascribed to these injuries only.

_____

_____

Please state any information not already mentioned which might be relevant to the assessment of any permanent disability arising from the accident _____

_____

_____

_____

Signature _____ Full names _____

Postal address _____

_____ Postal Code _____

Telephone code _____ Telephone number _____