Minet

Aon | Global Network Correspondent

STATED BENEFITS / GROUP PERSONAL ACCIDENT CLAIM FORM

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

This form is required in order to assess 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 Insurers or their representatives.

Only a fully completed and signed claim form can receive further consideration.

Section 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 and not the Insurer and / or anyone representing the Insurer.

Note that original medical accounts are required for reimbursement of medical expenses. In the event that the claim is in respect of a shortfall after any Medical Aid payments then a copy of the statement from the Medical Aid society is required.

SECTION 1 – GENERAL INFORMATION

Name of the Insured Group:

____

Name of the Subsidiary:

____

Policy Number:

____

Postal Address:

Contact Number(s):

Full Name of the Insured Person:

Date of Birth:

Identity Number:

Occupation:

Date of Accident:

Time of Accident:

Place of Accident:

Details of how the Accident occurred:

SECTION 2 – DISABILITY CLAIM

Details of the injuries sustained by the Insured Person:

Details of attending Doctor:

Name:

Telephone Number:

Address:

Please state the period during which the Insured Person was Totally Disabled from attending his/her usual occupation:

From:

To:

(both days included)

Date on which the Insured Person resumed work:

Is the Insured Person still receiving treatment from a Medical Practitioner?

If Yes – please give details:

Details of any Permanent Disability sustained as a result of this accident:

The following documentation / information are required:

1. Certified copy of the Inquest Report, including all witness statements pertaining thereto.
2. The Police accident report if the Disability was due to a Motor Vehicle Accident.
3. The Police Station reference number if the Disability is subject to a Criminal investigation.
4. Any newspaper clippings, eye witness statements or incident report / official hearings that may be available.
5. Wages Declaration

AUTHORISATION 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 the Insurers or their representatives with all information with regard to any injury, sickness, medical history, consultations, medication or treatment, including copies of my hospital medical records. I agree that a photocopy or fax copy of this authorisation shall be accepted as an original.

Signed: .... *Date:* ....

SECTION 3 – DEATH CLAIM

Date of Death:

Place:

Exact cause of Death and any factors connected therewith:

The following documentation / information is required:

1. Certified copies of the abridged and final Death Certificate.
2. Certified copy of the Post Mortem Report.
3. Certified copy of the Inquest Report, including all witness statements pertaining thereto.
4. The Police accident report if the Death was due to a Motor Vehicle Accident.
5. The Police Station reference number if the Death is subject to a Criminal investigation.
6. Any newspaper clippings, eye witness statements or incident report / official hearings that may be available.
7. Wages Declaration

SECTION 4 – EMPLOYERS CERTIFICATE

Full name of Employer:

Full name of the Insured Person:

Category within which the Insured Person falls under the Policy:

Was the Insured Person in your direct employment or 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:

Is there any Compensation payable in terms of the Workmen's Compensation Act or any other Insurer?

If Yes - please provide details:

DECLARATION BY THE 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.

Name: ....

Signature: ....

Capacity: ....

Date: ....

Company Stamp.

SECTION 5 – CERTIFICATE FROM USUAL MEDICAL ATTENDANT

Full names 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?

If Yes - please elaborate:

What is the prognosis?

What is the probable date of stabilisation?

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

How do you assess his/her motivation and rehabilitation potential?

Please state name and address of any other attending doctor(s):

Please state any further information that has not already been mentioned which may be relevant to the assessment of any disability arising from the accident:

DECLARATION:

Full Names & Surname (in block letters):

Signed:

Date:

Postal Address:

Telephone Number & Code: