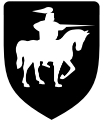

Prime Asset Cover

The Policy that protects You - The Prime Asset in your business

FORM PA-A05-001

INJURY / ILLNESS CLAIM FORM

POLICY NUMBER: ______ TYPE: ______

BROKER / AGENT: ______

INSURED	
NAME	
BUSINESS	
VAT Reg. No.	TEL No.
ADDRESS	

INSURED PERSON	
NAME & AGE	
BUSINESS OR OCCUPATION	

RELATIONSHIP OF INSURED PERSON TO INSURED	
IF EMPLOYEE GIVE ANNUAL EARNINGS DEFINED IN THE POLICY:	
IF OTHER	SPECIFY RELATIONSHIP:

INJURY / ILLNESS	
WHEN AND WHERE DID ACCIDENT OCCUR / ILLNESS COMMENCE	DATE: D D M M Y Y Y Y TIME:
GIVE FULL PARTICULARS OF THE ACCIDENT AND NATURE OF INJURIES OR THE NAME OF THE ILLNESS	PLACE:

WITNESS	NAME AND ADDRESS	
DOCTOR	DOCTOR WHO ATTENDED YOU	
NAME AND ADDRESS	YOUR USUAL DOCTOR	

DISABLEMENT		
PERIOD OF TEMPORARY TOTAL DISABLEMENT	FROM: D D M M Y Y Y Y	TO: D D M M Y Y Y Y
PERIOD OF TEMPORARY PARTIAL DISABLEMENT	FROM: D D M M Y Y Y Y	TO: D D M M Y Y Y Y
GIVE DATE NORMAL OCCUPATION RESUMED	DATE: D D M M Y Y Y Y	
HAS ANY PERMANENT DISABLEMENT RESULTED?	YES: Y NO: N	*IF YES GIVE DETAILS ON SEPARATE CLAIM FORM*

OTHER INSURANCES	GIVE NAME/S OF ANY OTHER INSURER WITH WHOM THE INSURED PERSON IS INSURED	

PREVIOUS CLAIMS	GIVE DETAILS OF ALL CLAIMS MADE AGAINST INSURERS OR IN TERMS OF COID BY THE INSURED PERSON	

WAS INSURED TESTED FOR ALCOHOL OR DRUGS? YES: Y NO: N

IF YES, WAS INSURED UNDER THE INFLUENCE OF ALCOHOL OR DRUGS? YES: Y NO: N IF YES, GIVE DETAILS ON SEPARATE FORM.

DECLARATION / AUTHORISATION

I/We acknowledge the sharing of claims information by insurers is essential to enable the insurance industry to underwrite policies and assess risks fairly and to reduce the incidence of fraudulent claims. In the public interest and with a view to limiting premiums, I/We hereby waive any right to privacy in any insurance or claims information supplied by me or on my behalf in respect of any insurance application or claim made or lodged by me/us and I/We consent to such information being disclosed to any other insurance company or its agent. I/We also waive any rights to privacy and consent to the disclosure of any information to any insurance claim concerning me or any insured person I/We represent. I/We further declare all the particulars true in every respect and correct, and I/We understand that if any claim lodged under this policy be in any respect fraudulent or if any fraudulent means or devices be used by me/us or anyone acting on my/our behalf or with my/our knowledge or consent to obtain any benefit under this policy or if any event be occasioned by the wilful act or with the connivance of me/us, the benefit afforded under this policy in respect of such claim shall be forfeited.

Insured's Signature ______ Date D D M M Y Y Y Y ______ Capacity ______

I hereby authorise any hospital, physician, or other person who has attended or examined me, to furnish to the company, or its authorised representative, all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

Insured Person's Signature ______ Date D D M M Y Y Y Y

P O Box 78518 SANDTON 2146 TEL: 011 886 3200 FAX 011 886 7303 - www.primeasset.co.za - primeasset@primeasset.co.za

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