

## INJURY/ILLNESS CLAIM

<b>Broker/Agent</b>	<b>Policy number</b>	<b>VAT reg. number</b>		
<b>Insured</b>	<b>Name and occupation</b>	_____		
	<b>Address and daytime phone number</b>	_____		
<b>Insured person</b>	<b>Name and age</b>	_____		
	<b>Business or occupation</b>	_____		
	<b>Address and phone number</b>	_____		
<b>Relationship to the Insured</b>	<b>If employee, give annual earnings defined in the policy</b>			<b>R</b>
	<b>If other, specify relationship</b>	_____		
<b>Injury/Illness</b>	<b>When and where did accident occur or illness commence</b>	<b>Date</b>	<b>Time</b>	<b>Place</b>
		_____	_____	_____
	<b>Give full particulars of the accident and nature of injuries, or the name of the illness</b>	_____		
		_____		
<b>Witness</b>	<b>Name and address</b>	_____		
		_____		
<b>Doctor</b>	<b>Name and address of doctor who attended to you</b>	_____		
		_____		
	<b>Name and address of your usual doctor</b>	_____		
		_____		
<b>Disablement</b>	<b>Period of temporary total disablement</b>	<b>From:</b> _____	<b>To:</b> _____	
	<b>Period of temporary partial disablement</b>	<b>From:</b> _____	<b>To:</b> _____	
	<b>Give date normal occupation resumed</b>	<b>Date:</b> _____		
	<b>Has any permanent disablement resulted</b>	_____		
	<b>Give details.</b>	_____		
		_____		
<b>Other insurances</b>	<b>Give name of any other insurer with whom insured person is insured</b>	_____		
		_____		
<b>Previous claims</b>	<b>Give details of all claims made against insurers or in terms of the WCA by the insured person. Compensation for Occupational Injuries and Diseases Act No. 150 of 1993.</b>	_____		
		_____		
<b>Declaration/ Authorisation</b>	I/We warrant that the answers given are true and correct. All details provided on this form are done so honestly and in good faith. This means that The Hollard Insurance Company Ltd has been made aware of all important information and that any incorrect information may mean that the claim may be rejected and the policy cancelled.			
<b>Protection of Personal Information</b>	We care about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this document. We will treat this information with caution and we have put reasonable security measures in place to protect it.			
	_____	_____	_____	
	<b>Insured's signature</b>	<b>Capacity</b>	<b>Date</b>	

I hereby authorise any hospital, physician, or other person who has attended or examined me to furnish to the company, or it's 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 photocopy of this authorisation shall be considered as effective and valid as the original.