

ACCIDENTAL DISABILITY CLAIM FORM

Policy underwritten by: The Standard General Insurance Company Limited "Stangen", an authorised long-term insurer licenced in terms of the Long-Term Insurance Act, 1998. Registration Number 1948/029011/06 (Authorised FSP: No 47235)

SECTION A: PARTICULARS OF THE INSURED

Policy Number

Surname First Names

Title Initials

ID. Number

Postal Address

Postal Code

Physical Address

Postal Code

Telephone (w) Fax (w)

Telephone (h) Fax (w)

Cell-phone Communication Preference

Email Address

Date of Disability

Y	Y	Y	Y	M	M	D	D
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Detailed description of cause of disability

Describe your symptoms and how they affect your ability to perform your occupational duties:

Have you previously suffered from the same or similar illness?

Yes	No
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If yes, from which date?

Y	Y	Y	Y	M	M	D	D
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On what date did the symptoms of the disability, for which you are claiming for start?

Y	Y	Y	Y	M	M	D	D
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From what date have you been totally disabled and unable to follow your normal occupation?

Y	Y	Y	Y	M	M	D	D
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Which duties of your normal occupation are you not able to do?

What is your height?

 M

Weight

 Kg

DETAILS OF YOUR FAMILY DOCTOR

Surname

Initials

Physical Address

Postal Code

Telephone (w)

State the names, addresses and dates of all doctors, hospitals and clinics consulted in connection with your condition, (please provide hospital or clinic reference numbers)

A. Doctor Address

Hospital / Clinic Reference Number
 Date Attended

B. Doctor Address

Hospital / Clinic Reference Number
 Date Attended

C. Doctor Address

Hospital/ Clinic Reference Number
 Date attended

Medical Aid Name Medical Aid Number

SECTION B: ACCIDENT DETAILS

Where did the accident take place?

Date of the accident

Nature of accident:

1 DETAILS OF WITNESS

First Name Surname

Title

Physical Address

Postal Code

2 DETAILS OF WITNESS

First Name Surname

Title

Physical Address

Postal Code

DETAILS OF POLICE STATION WHERE ACCIDENT WAS REPORTED

Name of Police Station

Physical Address

Postal Code

Telephone Number Case Number

Full name, rank and police number of investigation officer:

Details of any legal action taken as a result of the accident:

DETAILS OF POLICE STATION WHERE ACCIDENT WAS REPORTED

Doctor Initial

Address

Postal Code

Telephone Number

SECTION C: EMPLOYER DETAILS

1. Name of current Employer Employee / Clock Number

Employment Address

Postal Code

Telephone (w)

Date when you started working for your current employer?

Date when you were last actively able to do this job?

Type of Work Position Held

Percentage of hours spent on:

Travelling % Administration % Supervision % Manual Labour %

1. Name of previous Employer Employee / Clock Number

Employment Address

Postal Code

Telephone (w)

Employment start date to end date

Percentage of hours spent on:

Travelling % Administration % Supervision % Manual Labour %

2. Name of previous Employer Employee / Clock Number Employment Address Postal Code Telephone (w) Employment start date to end date

Percentage of hours spent on:

Travelling % Administration % Supervision % Manual Labour %3. Name of previous Employer Employee / Clock Number Employment Address Postal Code Telephone (w) Employment start date to end date

Percentage of hours spent on:

Travelling % Administration % Supervision % Manual Labour %**SECTION D: BANK DETAILS OF THE INSURED**Name of Bank Branch Name Account Number Branch Code Name of Account Holder Account Type Signature of Account Holder _____ Date

DECLARATION AND AUTHORISATION BY THE CLAIMANT

Policy Schedule Number

Declaration

I / we _____ declare that to the best of my/our knowledge all the information that I/we have given in this claim form is accurate and complete and that I/we have not withheld any information which could influence the decision on this claim. I/we further declare that I/we understand that my/our failure to disclose relevant information in respect of this claim may invalidate the claim. I / we acknowledge that I / we fully understand the contents of this declaration.

I / we acknowledge that I / we fully understand the contents of this declaration.

Authorisation

I / we hereby authorise Stangen or any of its representatives to obtain any information regarding this policy from any doctor, insurer or elsewhere that may be necessary to investigate this claim. I / we further authorise Stangen or any of its representatives to release any information regarding to this claim to any other interested parties that it deems necessary in respect of this claim.

I / we warrant that I am / we are legally entitled to the proceeds under this policy and that my / our estate(s) are solvent and have not been ceded or sequestrated.

Signed _____

On _____ day of _____ of 20 _____

SECTION F: TO BE COMPLETED BY STANGENPolicy Schedule Number Policy commencement date

Y	Y	Y	Y	M	M	D	D
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Date Claim received by STANGEN

Y	Y	Y	Y	M	M	D	D
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Details of Claims Committee Decision

Name Position

Signature _____