ONE

PRIME ASSET COVER

INJURY / ILLNESS CLAIM FORM

Policy Number		Type	
Broker / Agent			

INSURED

Name		Surname			
Business			VAT Number		
Address					
Tel					

INSURED PERSON

Name		Surname		Age	
Business or Occupation					

RELATIONSHIP OF INSURED PERSON TO INSURED

If employee, give annual earnings as defined in the Policy	
If other, specify relationship	

INJURY / ILLNESS

When and where did the accident happen / illness occur?

Date		Time	
Place			

Give full particulars of the accident and nature off injuries or the name of the illness

WITNESS

Name	
Address	

DOCTOR WHO ATTENDED TO YOU

Name	
Address	

ONE Insurance Underwriting Managers (Pty) Ltd Reg No. 1996/008987/07
Authorised Financial Services Provider FSP8783 VAT No. 4370160501

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YOUR USUAL DOCTOR

Name	
Address	

DISABLEMENT

Period of Temporary Total Disablement

From: To:

Period of Temporary Partial Disablement

From: To:

Date Normal Occupation Resumed

Has any Permanent Disablement Resulted? Yes ☐ No ☐

OTHER INSURANCES

Name/s of any other Insurer with whom the Insured Person is insured

PREVIOUS CLAIMS

Give details off all claims made against Insurers or in terms of COID by the Insured Person

Was the Insured tested for drugs or alcohol? Yes ☐ No ☐

If yes, was the Insured under the influence of drugs or alcohol? Yes ☐ No ☐

If YES, please provide full details: (complete seperate sheet if needed)

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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: _____

Capacity: _____ Date: _____

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: _____

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