CHUBB®

Contact us for more information:

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Claim form

Temporary & Permanent Disability

Please write in black ink and use block capital letters.

- Please return the completed claim form together with any enclosures to your insurance broker or to Chubb at the address shown
- The completion and/or submission of this claim form to us does not constitute an admission of your claim by Chubb Insurance Limited South Africa

Please ensure that the following documentation accompanies the claim form

- ☐ Confirmation of earning on company letterhead, signed by authorised representative of Company
- ☐ First Medical Report
- ☐ Final Medical Report stating the date on which the employee returned to work
- ☐ If the injury occurred on duty, then the claim is subject to the receipt of the COID act awards. Please supply details to Chubb.

Please ensure

- ☐ You fully complete every question **before** your doctor completes his statement
- ☐ Your attending doctor fully completes the statement

Personal details – to be completed by the policy holder

Name of Policy:

Certificate/Policy Number:

Title: Miss

Full Name of Insured Person:

Date of Birth:

ID No:

Tel. No (Business):

Physical Address:

Tel. No (Home):

Fax No:

Cell phone No:

Email:

Accident details

Please give exact date and time of the accident:

Date:

Time:

Am/Pm:

Title:

Miss

Full Name of Insured Person:

ID No:

Where did the accident occur?

How did the accident occur?

Full details of injuries sustained:

Have you previously claimed under this or a similar policy? ☐ Yes ☐ No

If Yes, please give details:

If injured on duty has the claim been submitted to COID? ☐ Yes ☐ No

What was the injured person's occupation at the time of the accident?

Employment details

Please note this must be completed by the employer:

a) Is the claimant weekly / monthly remunerated?

b) What is the average weekly / monthly earnings?

c) What is the claimant's occupation?

d) Has the claimant been booked off work? ☐ Yes ☐ No

If Yes, please provide dates:

From:

Returned:

Employer – it is important that you ensure you sign hereunder.

Signed:

Company Stamp:

Company designation:

Date:

Medical expenses

Is the claimant a member of a Medical Aid/Scheme? ☐ Yes ☐ No

Name and contact details of Medical Aid/Scheme:

Scheme Name:

Membership Number:

Authorisation

Please note that this claim form will only be accepted if this declaration has been signed by the policyholder, claimant or authorised person.

I _____ hereby warrant that the information given in this claim form is every respect complete, correct and true.

I authorise any medical practitioner, hospital or other person to provide Chubb Insurance Limited with any information they require relating to my medical history and the injury/illness to which the claim relates. I agree that this consent shall remain in force at all times, and that a photo-copy or fax for this declaration shall be accepted as original. I agree and accept that Chubb Insurance Limited may request additional information from any medical practitioner, hospital or any other person not specifically requested herein, on completion and submission of this form and any other documentation as submitted by me.

Signed by the claimant or his/her legal representative on this _____ day of _____ 20 _____

Signature _____

Doctor's statement

This section must be fully completed by the patient's usual medical attendant – any fee for completion of this section is the responsibility of the insured person.

Title: Miss

Patients Full Name and Surname:

Date of Birth:

Height:

Weight:

Full details of injuries sustained:

Final diagnosis:

When did the patient first recieve medical attention for the injuries sustained?

Has the patient ever suffered with this or any similar condition before the present episode? ☐ Yes ☐ No

If Yes, please give details including dates of treatments and consultations:

Can this be attributed to any other underlying condition?

Are you the patient's usual family doctor? ☐ Yes ☐ No

If No, please give name and address of usual doctor:

Disability

a) On what date did incapacity commence?

b) Is the patient still incapacitated? ☐ Yes ☐ No

c) If Yes, when will the patient be able to return to work?

d) If No, when did incapacity cease?

e) Is the patient able to follow his/her usual occupation?

f) Will the inujury in question avoid the claimant from following his/her usual occupation? ☐ Yes ☐ No

g) To what extent can permanent disability (if any) be ascribed to this injury alone?

Full Name of Doctor:

Practice Number:

Dr Signature:

Date:

Full Address:

Contact Number:

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