

Old Mutual Insure Limited. Reg No:
1970/006619/06 VAT No: 4460101019
Authorised Financial Services Provider (FSP 12)
Gemagtigde Finasiele Diensverskaffer (FDV 12)

		POLICY NO.	POLISNR.			
		CLAIM NO.	EISNR.			
BROKER/AGENT		MAKELAAR/AGENT				
Insured	NAME AND BUSINESS	NAAM EN BESIGHEID			Versekerde	
	VAT REGISTRATION NO.	BTW REGISTRASIE NR.				
	ADDRESS AND DAY TELEPHONE NO.	ADRES EN DAG TELEFOONNR.				
Insured Person	NAME AND AGE	NAAM EN OUDERDOM			Versekerde Persoon	
	BUSINESS OR OCCUPATION	BESIGHEID OF BEROEP				
Relationship of insured person to insured	If employee, give annual earnings defined in the policy	Indien werknemer, verskaf jaarlikse verdienste soos uiteengesit in die polis			Van Versekerde persoon aan versekerde	
	If other, specify relationship	Indien anders, verstrek besonderhede van verwantskap				
Injury / Illness	When and where did accident occur or illness commence?	Date / Datum	Time / Tyd	Place / Plek	Besering / Siekte	
	Give full particulars of the accident and nature of injuries or the name of the illness	Wanneer en waar het ongeluk plaasgevind of siekte begin?				
Witness	Name	Naam			Getuies	
	Address	Adres				
Doctor	Name and address of Doctor who attended to you	Naam en adres van geneesheer wat u behandel het			Geneesheer	
	Name and address of your usual Doctor	Naam en adres van u eie geneesheer				
Disablement	Period of temporary total disablement	From Van	To Tot	Tydperk van tydelike algehele ongeskiktheid	Ongeskiktheid	
	Period of temporary partial disablement	From Van	To Tot	Tydperk van tydelike gedeeltelike ongeskiktheid		
	Give date normal occupation resumed	Date Datum	Meld datum waarop normale werk hervat is			
	Has any permanent disablement resulted? Give details	Verskaf besonderhede van enige permanente ongeskiktheid wat veroorsaak is				
Other Insurances	Give name of any other insurer with whom insured person is insured	Verskaf naam van enige ander versekeraar deur wie die versekerde persoon verseker is			Ander Versekering	
Previous Claims	Give details of all claims made against insurers or in terms of WCA by the insured person	Verskaf besonderhede van enige eis ingedien teen versekeraars of kragtens die ongevallewet deur versekerde persoon			Vorige Eise	

Declaration / Authorisation	I/We declare that the above particulars are true in every respect. Ek/Ons verklaar dat die bovermelde besonderhede in elke opsig waar is.				Verklaring / Magtiging
	Insured's Signature Versekerde se Handtekening	Capacity Hoedanigheid	Date Datum		
	<p align="center">IMPORTANT</p> <p>I hereby authorise any hospital, physician, or other person who has attended or examined me, to furnish 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 photostatic copy of this authorisation shall be considered as effective and valid as the original.</p> <p align="center">BELANGRIK</p> <p>Hierby magtig ek enige hospital, geneesheer of ander persoon wat my behandel of ondersoek het, om alle inligting in verband met enige siekte of besering, mediese geskiedenis, konsultasie, voorskrifte of behandeling en afskrifte van alle hospital of mediese verslae aan die maatskappy of sy gemagtigde verteenwoordiger te verstrek. 'n Fotostaat van hierdie magtiging sal as net so doeltreffend en geldig as die oorspronklike beskou word.</p>				

Insured person's signature
handtekening

Versekerde persoon

MEDICAL CERTIFICATE – MEDIESE SERTIFIKAAT

MUST BE COMPLETED BY THE DOCTOR CONSULTED

MOET DEUR DIE GENEESHEER WIE GERAADPLEEG IS VOLTOOIWORD

The Patient must obtain, at his own expense, the following certificate from a duly qualified and registered Medical Practitioner

Die Pasiënt moet op eie onkoste die volgende sertifikaat van 'n behoorlike gekwalifiseerde Mediese Praktisyn verkry.

When the Patient is fully recovered a doctor's certificate to that effect should be forwarded to the Insurers showing the periods of partial and total incapacity. Wanneer die Pasiënt ten volle herstel het moet 'n doktersertifikaat tot dien effek en wat die tydperk van gedeeltelike en algehele ongeskiktheid aantoon, aan die Versekerars gestuur word.

NAME OF PATIENT HEIGHT MASS
NAAM VAN LENGTE... MASSA.....
PASIËNT.....

- 1. When did you first attend upon the Patient in consequence of the Accident/Illness sustained?
2. Are you still in attendance?
3. Are you the usual medical attendant of the Patient, and if so, how long have you known him/her?
4. What was the cause of the Accident/Illness so far asknown?
5. What injuries were sustained?
6. Have you any reason to suspect that the Patient was not perfectly sober at the time of the Accident/
7. Is the Patient now, or was he/she at the time of the Accident/Illness subject to or suffering from any illness or disease irrespective of the Accident/Illness for which the benefit is claimed?
8. If you are the usual Medical Attendant of the Patient, are you aware of anything in his/her previous medical history which might have contributed directly or indirectly, to the occurrence of the Accident/Illness, or which may be likely to retard in any way recovery from it?
9. (a) Is Patient confined to bed, bedroom, or house by your directions/
(b) Has Patient at any time been so confined since the date of the Accident/Illness?
10. If still so confined, please state: (a) Your opinion as to the probable duration of such confinement; (b) Probable date of being able to resume some portion of usual business or occupation:
11. Are you prepared to certify that the Patient is TOTALLY disabled from attending to any portion of his/her business or occupation?
12. If Patient has been able to attend to a PORTION only of his/her usual business or occupation, and if this still continues, please state since when and also probable date of recovery.

13 If Patient has recovered, please state date of recovery.

. As die Pasiënt reeds herstel het, meld asseblief die datum van herstel

GENERAL REMARKS:

ALGEMENE

OPMERKINGS.....
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I certify that the foregoing statements are correct:

Ek sertifiseer dat die voorafgaande verklarings jus is:

Name:

Naam:

Qualifications:

Kwalifikasies:

Address:

Adres:

Signature:

Handtekening:

Date:

Datum: