INJURY / ILLNESS CLAIM FORM

TRUSTCO claims company

INSURER		**POLICY NUMBER**			**VAT REG NUMBER**		
INSURED	Name & Occupation						
	Address & Phone No.						
INSURED PERSON	Name & Age						
	Business or Occupation						
	Address & Phone No.						
RELATIONSHIP OF INSURED PERSON TO THE INSURED	If employee give annual earnings defined in the policy						
	If other, specify relationship						
INJURY / ILLNESS	When and where did accident occur or illness commence?	Date		Time		Place	
	Give full particulars of the accident and nature of injuries or the name of the illness						
WITNESS	Name & Address						
DOCTOR	Name and address of doctor who attended to you						
	Name and address of your usual doctor						
DISABLEMENT	Period of temporary total disablement	From			To		
	Period of temporary partial disablement	From			To		
	Give date normal occupation resumed	Date					
	Has any permanent disablement resulted? Give Details						
OTHER INSURANCES	Give name of any other insurer with whom insured person is insured						
PREVIOUS CLAIMS	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						

DECLARATION & STATEMENT

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 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 relevant to any insurance claim concerning me or any insured person I/We represent.
I/We further declare that all particulars to be 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 occassioned 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 _____

IMPORTANT

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 tretment, 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 _____