UNDERWRITING MANAGERS

Tel: 0861-00-0090
E-mail: claims@keu.co.za
Website: www.keu.co.za

GROUP PERSONAL ACCIDENT CLAIM FORM

- **This form is required in order to assess a pending claim under a Policy of Insurance. Issue and completion of this form does not in any way imply, construe or admit liability by the Insurers' or their representatives.**
- **Only a fully completed and signed claim form can receive further consideration.**
- **Proof of Medical Accounts to accompany the completed claim form**
- **Section 1, 2, and 3 are to be completed by the Insured group or the Subsidiary claiming and by the Medical Attendant.**
- **Please note that payment for any expenses incurred in the completion of this form is the responsibility of the claimant and not the Insurer and/or anyone representing the Insurer.**
- **Note that original medical accounts are required for reimbursement of medical expenses. In the event that the claim is in respect of a shortfall after any Medical Aid payments then a copy of the statement from the Medical Aid society is required.**

PLEASE ATTACHED A COPY OF THE FOLLOWING DOCUMENTS WITH THE COMPLETED CLAIM FORM		
	1.	CERTIFIED COPIES OF THE ABRIDGED AND FINAL DEATH CERTIFICATE – IF APPLICABLE
	2.	CERTIFIED COPY OF THE POSTMORTEM REPORT– IF APPLICABLE
	3.	CERTIFIED COPY OF THE INQUEST REPORT, INCLUDING ALL WITNESS STATEMENTS PERTAINING THERETO
	4.	THE POLICE ACCIDENT REPORT IF THE DEATH WAS DUE TO A MOTOR VEHICLE ACCIDENT
	5.	THE POLICE STATION REFERENCE NUMBER IF THE DEATH IS SUBJECT TO A CRIMINAL INVESTIGATION
	6.	ANY NEWSPAPER CLIPPINGS, EYEWITNESS STATEMENTS OR INCIDENT REPORT/OFFICIAL HEARINGS THAT ARE AVAILABLE
	7.	ANY RELATED MEDICAL REPORTS, CERTIFICATES, AND INVOICES
	8.	EMPLOYMENT CONTRACT OF INJURED THIRD PARTY

INSURED:			
POLICY NUMBER:	KEU	BROKER	
NAME OF INSURED:		CONTACT DETAILS	

WAS THE INJURED PARTY UNDER YOUR EMPLOYEMENT AT THE TIME OF THE INCIDENT? IF YES, PLEASE INCLUDE CONTRACT AGREEMENT	YES	NO

PURPOSE OF EMPLOYMENT				
TYPE OF LOSS:	MEDICAL EXPENSE	TEMPORARY DISABILITY	TOTAL DISIBILITY	DEATH

DETAILS OF INJURED PARTY:			
FULL NAME		CONTACT DETAILS	
DATE OF BIRTH	Day / Month / Year	ID NUMBER	

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OCCUPATION				
DATE OF ACCIDENT:	Day / Month / Year	TIME OF ACCIDENT:		AM / PM
LOCATION WHERE INJURY OCCURED:				
PARENT / GUARDIAN NAME		CONTACT DETAILS		
HAVE YOU INJURED THE SAME AREA BEFORE?			YES	NO
HAVE YOU MADE A CLAIM AGAINST ANY OTHER PARTY IN RESPECT OF THIS EVENT / INJURY?			YES	NO
IF YES PLEASE PROVIDE DETAILS:				
DESCRIPTION OF INJURY SUFFERED:				
DETAILS OF HOW THE ACCIDENT OCCURRED:				
SECTION 2 - DEATH CLAIM:				
DATE OF DEATH:	Day / Month / Year	LOCATION:		
EXACT CAUSE OF DEATH AND ANY FACTORS CONNECTED THEREWITH:				

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MEDICAL REPORT: TO BE COMPLETED BY ATTENDING DOCTOR							
Hospital name:				Contact details:			
Full patient name				Date of accident:	Day / Month / Year		
Date of first consultation	Day / Month / Year	Date admitted	Day / month / year	Date discharged	Day / Month / Year		
Cause of injury							
Nature and extent of the injury describe complications, if any							
Attending doctor name:				Contact details:			
Official diagnosis:							
Treatment provided to date:							
How long has the patient been disable from engaging in or attending to usual employment or occupation as a result of these injuries?	TOTAL	FROM	Day / Month / Year	TO	Day / Month / Year		
	PARTIALLY	FROM	Day / Month / Year	TO	Day / Month / Year		
Does the present injury relate in any way to previous injuries or pre-existing illnesses?					YES	NO	
If yes please give details:							
At the time of accident, was the patient suffering from any illness/ intoxicated?	YES			NO			
Details of any circumstances which may have contributed to the accident and/or lengthen the period of disability:							
Any other information or professional advice that should be made known:							
Is permanent disability expected?	YES			NO			
If Yes, provide full details,							
If No, has his/her condition stabilized							
Attending doctor name				Contact details:			
Signature				Date:	Day / Month / Year		

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AUTHORISATION TO BE COMPLETED BY THE INSURED PERSON OR HIS/HER LEGAL REPRESENTATIVE.

I hereby authorise any hospital, physician, or other person who has treated me to furnish the Insurers or their representatives with all information with regard to any injury, sickness, medical history, consultations, medication, or treatment, including copies of my hospital medical records. I agree that a photocopy or fax copy of this authorisation shall be accepted as an original.

SIGNED:		DATE:	Day / Month / Year

DECLARATION

I/We warrant that the answers given are true and correct. All details provided on this form are done so honestly and in good faith. This means that KEU Underwriting Managers (PTY) LTD has been made aware of all important information and that any incorrect information may mean that the claim may be rejected, and the policy cancelled.

I consent to KEU Underwriting Managers, Centriq and its operators, processing and further processing, my personal information in accordance with the Protective of Personal Information Act, for the purpose of concluding and performing in terms of this insurance contract.

For further information please read our Private Notice, which can be found on www.centriq.co.za

NAME OF INSURED:		SIGNATURE	
DATE:	Day / Month / Year	CAPACITY:	