LEARNER PERSONAL ACCIDENT CLAIM FORM

IMPORTANT – All Claims must be notified as soon as possible, but within no more than 90 days from the date of the injury. Failure to do so will result in the Claim being declined due to Late Notification.

This form is required in order to assess a potential Claim under a Policy of Insurance. Issue and completion of this form does not in any way imply, construe or admit liability by the Insurer. Only a fully completed and signed claim form can receive our further consideration.

Section 1: GENERAL

Name of insured _____

Contact person _____

Policy Number _____

Contact number _____ Email address _____

Name of claimant _____

Date of birth _____ Grade _____

Accident date _____ Accident time _____ Accident place _____

Policy Number _____

Was this injury during working hours/school activities? Yes ☐ No ☐

Give a detailed description of how the accident occurred. _____

Cause of injury, please tick:

Athletics ☐	Basketball ☐	Canoeing/Rowing ☐	Cricket ☐	Cycling ☐	Cross Country ☐
Hockey ☐	Rugby ☐	Soccer ☐	Squash ☐	Swimming ☐	Tennis ☐
Waterpolo ☐	Other ☐	Other, please specify _____			

Nature of injury, please tick:

Ankle ☐	Arm ☐	Back ☐	Chest ☐	Concussion ☐	Dental ☐
Ear ☐	Elbow ☐	Eye ☐	Face ☐	Finger ☐	Foot ☐
Groin ☐	Hamstring ☐	Hand ☐	Head ☐	Hip ☐	Jaw ☐
Knee ☐	Leg ☐	Mouth ☐	Neck ☐	Nose ☐	Ribs ☐
Shoulder ☐	Spine ☐	Toe ☐	Wrist ☐	Other ☐	

Other, please specify _____

Section 2: DEATH – See Annexure A

Section 3: PERMANENT DISABILITY CLAIM – See Annexure B

Section 4: TTD/INCOME REPLACEMENT BENEFIT (if applicable) – See Annexure C

Section 5: NON-MEDICAL EXPENSE COVER AS A RESULT OF HOSPITALISATION BENEFIT (if applicable)

An original Hospital Account proving admission into hospital and discharge dates is required when claiming under this section.

Section 6: EMERGENCY EXPENSES SHORTFALL BENEFIT (if applicable)

Original Medical Accounts and copies of the relevant Medical Scheme statements associated with the treatment of Injuries sustained as a result of the Accident, are required when claiming under this section. Please remember that only Medical costs not paid by a registered Medical Scheme will be considered under this section, which includes Medical Accounts paid directly from a Member's Medical Scheme Savings account. Any costs recoverable from COID and/or RAF will not be paid under this section, but should be referred to Accident Expert for assistance in recovering these costs.

AUTHORISATION BY CLAIMANT

Authorisation to be completed by the Claimant or his/her legal representative.

- I hereby authorise any hospital, physician or any other person who treated me, to furnish the Insurer or the legal representatives with all information with regard to any Injury, sickness medical history, consultations, prescription or treatment including copies of all my hospital or medical reports.
- I agree that a photostat/fax copy of this authorisation shall be accepted as the original.
- I declare that the answers given by me in this claim form are true in every respect.
- I agree to co-operate where additional reports are called for by the Insurer, which may require me to attend further medical assessments with Insurer appointed Medical Professionals. I understand that any costs associated with this Insurer request will be for the Insurers cost.
- I further consent to the Insurer processing my or my minor dependent's Personal Information (if applicable) provided in relation to this Claim, including but not limited to full name and identity number and medical information as is required under the first bullet noted above, for the purposes of the assessment of the Claim notified herein. I understand that should such consent not be granted by me, that Insurers will not be able to attend to the assessment of the Claim so submitted.
- I understand that certain further information regarding the Claim notified may be obtained from other sources such as South African Police Services or through loss adjustors/legal advisors/investigators in order for the Insurer to properly investigate the circumstances giving risk to the Claim.

In proceeding with this claim, I wish to request that all future communication should be sent to:

- Myself (the Claimant) directly OR
- The Insured/Policy Holder OR
- Both the Insured/Policy Holder and Myself

I understand that the Intermediary/Broker will be copied in on all correspondence.

Signature of the Claimant or his/her legal representative

Date _____

_____ Place _____

No claim will be settled unless accompanied by the following:

- Proof of Banking Details
- Copy of Invoice together with Proof of Payment for the treatment being claimed

DECLARATION BY LEGAL GUARDIAN OF MINOR CHILD

I hereby warrant the truth of all particulars on this form in every respect and declare that all conditions of this Insurance have been complied with.

I/We acknowledge that the information submitted in this proposal form may be protected by data protection legislation, such as the Protection of Personal Information Act 2013 (POPI) and accordingly hereby consent to the use of such information by SHA/Santam Limited (the Insurer) and Bay Union Insurance Brokers (the Broker) to:-

- Verify the information disclosed herein against any other source.
- Communicate with you directly should you request us to and in accordance with relevant regulatory requirements.
- Properly and appropriately assess the Claim submitted by me herein in the legitimate interests of the Insurer and/or Claimant/ Insured Employee/Pupil.
- Compile non-personal statistical information to assist in assessing similar risks.
- Transmit your personal information to any affiliate, subsidiary or re-insurer so that we can provide insurance services to you and to enable us to further our legitimate interests including statistical analysis, reinsurance and credit control;
- Transmit your personal information to any third party service provider who has a need to know such information in order to perform functions relating to your Policy;
- Share your personal information on the SAIA policyholder database for the combatting of insurance fraud and improved evaluation of risks.

I/We further acknowledge that this consent clause will remain in force even if this Policy is cancelled or lapses.

I further understand that I have the right to object, on reasonable grounds, to the processing of any Personal Information provided to the Insurer but that this may mean that the Insurer will not be able to complete the assessment of the Claim in question.

Claimant Signature

Date _____

_____ Capacity _____

Signature (School Representative)

Date _____

_____ Capacity _____