OLEA
INSURANCE SOLUTIONS AFRICA

INJURY/ILLNESS CLAIM

Broker/Agent: _____ Policy number: _____ VAT reg. number: _____

Insured

Name and occupation: _____

Address and daytime phone number: _____

Insured person

Name and age: _____

Business or occupation: _____

Address and phone number: _____

Relationship to the Insured

If employee, give annual earnings defined in the policy: R _____

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 and 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/ Authorisation

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 the Insurer 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.

Protection of Personal Information

We care about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this document. We will treat this information with caution and we have put reasonable security measures in place to protect it.

_____ _____ _____

Insured's signature Capacity Date

I hereby authorise any hospital, physician, or other person who has attended or examined me to furnish to the company, or it's 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 photocopy of this authorisation shall be considered as effective and valid as the original.