OLDMUTUAL

PERSONAL/SCHOLARS ACCIDENT OR ILLNESS CLAIM FORM

IN THE CASE OF INFECTIOUS DISEASE THIS FORM SHOULD NOT BE TOUCHED BY THE PATIENT

Agency ..... Policy No. ..... Claim No. .....

This form is issued without admission of liability, and must be completed and returned within seven days after its receipt. No claim can be admitted unless a MEDICAL CERTIFICATE, at the Claimant's expense is furnished.

1. Name in full	Present age
Telephone No: Bus..... Home ..... Cell	.....years
Residence/School.....	Height
Business Address.....	Weight
Present Business or Occupation..... e-mail ..... (if more than one state all)	

If you are claiming in respect of an ACCIDENT: 2. (a) How, when and where did the accident occur? (b) What injuries were sustained?	
3. Give the names and addresses of anyone who saw the accident	

If you are claiming in respect of ILLNESS: 4. (a) Nature of illness (b) When did illness first start (c)Where was the illness contracted?	
5. Has claimant ever suffered before from the illness now claimed for?	

Answer questions 6 to 10 in ALL cases: 6 .(a) Name and address of the Doctor who first attended (b) Name and address of usual Doctor	
7. State where and when a Medical or Other Representative of the Company can visit, if necessary.	
State: 8. (a) From what date totally disabled and prevented from attending business/school as the sole and direct result of the accident or illness (b) Whether still totally disabled. If not, from what date was claimant able to attend to some part of normal business/school activities	
9. Has claimant previously claimed or received compensation under an Accident and/or Sickness policy? If so, please give particulars.	
10. Is claimant insured elsewhere? If so, give the name of each Company or Insurer, and the amount entitled to claim.	

I, the undersigned, do hereby declare that to the best of my knowledge and belief the foregoing particulars are true and correct.

Date ..... **Signature of Insured/on behalf of the School** .....

P.T.O

PRIVATE AND CONFIDENTIAL

Medical Certificate to be completed by Insured's Doctor/Claimant's

MEDICAL PRACTITIONER

I **CERTIFY** that .....

has consulted me for .....

The patient $\frac{\text{was injured}}{\text{became ill}}$ on.....

If the patient's condition is complicated by any other disease or infirmity, please give details:

.....

.....

.....

If illness, is the present complaint likely to recur?.....

The patient is $\frac{\text{totally}}{\text{partially}}$ disabled and will be so disabled until.....

Are the injuries consistent with the accident described overleaf? .....

.....

Signature and
Qualifications .....

Date .....

Total Disablement occurs when the claimant is wholly prevented from attending to his business/occupation/school.

Partial disablement when prevented from attending to a substantial portion thereof.

OFFICIAL USE

Section in respect of which payment made:	**Calculation**
Period of disablement From ..... To ..... Total Days	