GUARDRISK
TAILORED RISK SOLUTIONS
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COMPENS8 PERSONAL ACCIDENT CLAIM FORM

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	
Name of Injured Person	
ID Number	
Date, time & place of accident	
Is this an Injury on Duty	
SAPS & OAR case number	
Give a detailed description of how the accident occurred.	

The following documentation must be provided for this claim to be considered: -
NOTE: It is not necessary to have all these documents when submitting the claim. These documents can be forwarded at a later stage to avoid any unnecessary delays.

1. Certified Copy of the injured`s ID.
2. Copy of the accident Report
3. Copy of the police report in the event of a motor vehicle accident.
4. Details of witnesses.

Section 2A: Accidental Death Claim (if applicable)

Date & Place of death	
State the exact cause of death and any important factors connected therewith.	

The following documentation must be provided for this claim to be considered: -
NOTE: It is not necessary to have all these documents when submitting the claim. These documents can be forwarded at a later stage to avoid any unnecessary delays.

1. Certified Death Certificate
2. Certified Post Mortem Report
3. Police Accident Report if the death was due to a motor vehicle accident
4. Police Reference number if death is the subject of a criminal investigation
5. Copies of any newspaper clipping or eye witness statements that may be available

SECTION 2B **Final Rest** ***submit:***

1. ***Certified Death Certificate***
2. ***Post Mortem***
3. ***Incident Report***

Section 3: Disability Claim

Give full details of the injuries sustained by the claimant	
Name of the attending doctor	
Practice Number	
Tel No	
Address	
Has any permanent disablement resulted from this accident, if yes, please give details:	

Section 4: Temporary Income Replacement (TTD)

. The following supporting documents will be required when claiming for this Benefit.

- Confirmation of earnings
- Medical report
- If involved in a motor vehicle accident, a police/accident report

Give full details of the injuries sustained by the claimant	
Name of the attending doctor	
Practice Number	
Tel No	
Address	

Section 5: Hospitalisation Benefit

The following documents will be required when claiming for the Hospitalisation Benefit.

- Original Medical Accounts proving admission into hospital and discharge dates

AUTHORISATION

Authorisation to be completed by the claimant or his/her legal representation.

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.

Signature of the Claimant or his/her legal representative	
Date	
Place	

Declaration by Insured Person

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:

Signature:	
Date:	
Capacity	

MEDICAL CERTIFICATE

This certificate is to be completed by the doctor consulted

The claimant must obtain, at his/her own expenses, the following certificate from a duly qualified and registered medical practitioner who treated him/her for his/her injuries. When the claimant is fully recovered, a doctor's certificate to that effect must be forwarded to the Insurer showing the periods of partial and total incapacity.

Full name of patient	
When were you first consulted by the claimant in connection with his/her injuries	
Are you still in attendance	
What was the cause of the accident so far as known	
What injuries were sustained	
Please state the exact cause and nature of the disability and any important factors connected therewith	
Does the present disability relate in any way to previous injuries or pre-existing conditions or illness	
If yes, please explain	
Is the patient now or was he/she at the time of the accident subject to or suffering from any illness or disease irrespective of the accident for which the benefit is claimed?	
If so, state the nature of it, and to what extent the recovery of the patient may be effected thereby	
Is the patient temporarily or permanently disabled from attending to any portion of his/her usual business or occupation	
If yes, please explain.	
Please state any information not already mentioned which is relevant to the assessment of any permanent disability arising from the accident	
If the patient has fully recovered, please state the date of recovery	

In the event of Serious Illness confirm and provide the following

Was this a newly diagnosed Illness?	**Yes**	**No**
Date of Diagnosis		
Type of Illness		
Have you claimed, from this policy, for any of these illnesses before?	**Yes**	**No**
	If yes, please give full detail:	
	Type of Illness	
	Date of Diagnosis	
	Date of Payment	
When did the symptoms first appear?		
When did you first consult a doctor for this condition?		
Name, Address and Telephone Number of the doctor consulted		
Name, Address and Telephone Number of the hospital(s) where you have been treated for this condition		
Details of medical assistance sought in the last 5 years (minor illnesses such as colds and flu may be omitted)		
Name, Address and Telephone Number of your usual doctor		

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

I hereby authorise any hospital, physician or any other person who has treated me to furnish the Insurer or its legal representatives with all information with regard to any injury, sickness medical history, consultations, prescriptions or treatments including copies of all my hospital or medical records. 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.

Signature of the Claimant or his/her legal representative: _____

Date: _____ Place: _____

SERIOUS ILLNESS MEDICAL CERTIFICATE

This certificate is to be completed by the doctor consulted

The claimant must obtain, at his/her own expenses, the following certificate from a duly qualified and registered medical practitioner who treated him/her for his/her injuries. When the claimant is fully recovered, a doctor's certificate to that effect must be forwarded to the Insurer showing the periods of partial and total incapacity.

(Please complete sections 1 & 10 and the appropriate one of sections 2 to 9)

Section 1 – General

Patient's Name		
Age		
Are you the patient's usual medical attendant?	**Yes**	**No**
	If "yes", please give details of the patient's medical/surgical history for the last 12 months prior to hospitalisation	
When did the patient first become aware of the symptoms?		
When was medical advice sought?		
Has the patient suffered from this disease in the past?	**Yes**	**No**
	If "yes", please give details	
Do you know of any hereditary disease in the patient's family?	**Yes**	**No**
	If "yes", please give details	
Do you know of any factors regarding past or present health, habits or lifestyle which may have contributed to any health problems?	**Yes**	**No**
	If "yes", please give details	
Do you know of any hereditary disease in the patient's family?	**Yes**	**No**
	If "yes", please give details	

Select the applicable illness (*x*)

Cancer		**Motor Neuron Disease (resulting in permanent symptoms)**		**Paraplegia**	
Coronary Artery Surgery		**Alzheimer's**		**Multiple Sclerosis (with persisting symptoms)**	
Heart Attack		**Coma (resulting in permanent neurological complications):**		**Blindness**	
Stroke (resulting in permanent symptoms)		**Parkinson's Disease**		**Major Organ Transplant**	
Kidney Failure		**Heart Valve Surgery**			

Section 2 – Cancer

This is defined as a malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.The following conditions are excluded from this definition:

- All cancers in situ and all pre-malignant conditions.
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
- All skin cancers, other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

State the site and extent of the neoplasm		
Is it malignant or non-malignant?		
Has staging been carried out?	**Yes**	**No**
	If "yes", please give details Please comment on invasion of metastases	

Section 3 – Coronary Artery Surgery

This is defined as the actual undergoing, on the advice of a consultant surgeon, of coronary artery bypass surgery to correct stenosis or occlusion in the coronary arteries but excluding angioplasty, keyhole surgery and other non-surgical techniques such as laser procedures.

State the type of procedure done and date perform	
What were the events predisposing to surgery	

Section 4 – Heart Attack

This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by two of the following three criteria:

- Compatible clinical symptoms
- Characteristic ECG changes, which can be either of the following:
  - New pathological Q-waves as defined below, or
  - ST-segment and T-wave changes indicative of myocardial ischaemia that may progress to myocardial infarction, as defined below, but only when accompanied by raised cardiac markers as described below.
- Pre-intervention raised cardiac markers:
  - Trop T greater than 1,0 ng/ml, or
  - Trop I greater than 0,5 ng/ml, or
  - CK-MB mass greater than two times the normal values in acute presentation phase, or
  - Total CPK elevation of greater than two times the normal values, with at least 6% being CK-MB.

The evidence must show a definite acute myocardial infarction. Other acute coronary syndromes, including but not limited to angina, are not covered by this definition.

For purposes of this definition, new pathological Q-waves mean the following:
Any Q-wave in leads V1 through V3, Q-wave greater than or equal to 30 ms (0.03s) in leads I, II, AVL, AVF, V4, V5or V6. The Q-wave changes must be present in any two contiguous leads, and be greater than or equal to 1mm in depth ECG changes indicative of myocardial ischaemia that may progress to myocardial infarction, mean the following:

- Patients with ST-segment elevation:
  - New or presumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to 0.2mV in leads V1, V2,or V3, and more or equal to 01.mV in other leads. Contiguity in the frontal plane is defined by the lead sequence AVL, I, inverted AVR, II, AVF, III.
- Patients without ST-segment elevation:
  - ST-segment depression.
  - T-wave abnormalities only

State the type and extent of the infarction		
Is there a history of chest pain?		
State the new ECG changes and the date the ECG done		
Has an ECG ever been done before?	**Yes**	**No**
	If "yes", please give details	

When was the test done and what were the cardiac enzyme levels?									
CPK		**AST**		**MBCK**		**CK**		**LDH**	
State the following UP levels, if done and the dates									

Section 5 – Kidney Failure
This is defined as Chronic end stage failure of both kidneys to function, as a result of which regular dialysis is necessary.

Is there chronic irreversible failure of both kidneys		
Give the dates and results of the kidney function tests done		
Has regular renal dialysis been instituted	**Yes**	**No**
Please state the frequency of dialysis		

Section 6 – Major Organ Transplant
This is defined as which shall mean the actual undergoing as a recipient of a transplant of the heart, liver, pancreas, bone marrow or at least one of the kidneys or lungs.

What organ was replaced?	
What was the underlying disease?	
For how long was the disease present?	
What was the source of the replacement?	

Section 7 – Multiple Sclerosis
This is defined as a definite diagnosis of multiple sclerosis by a neurologist. There must be current clinical impairment of motor or sensory function of an EDSS scale 3.0 or more, which must have persisted for a continuous period of at least 6 months. Benign multiple sclerosis will not be covered.

Has the following neurological investigations been done?	Lumber puncture	**Yes**	**No**
	If "yes", please give the date the procedure was done and attach the results		
	Evoked visual responses	**Yes**	**No**
	If "yes", please give the date the procedure was done and attach the results		
	Evoked auditory responses	**Yes**	**No**
	If "yes", please give the date the procedure was done and attach the results		
	MRI scan	**Yes**	**No**
	If "yes", please give the date the procedure was done		
Was there evidence of any lesion of the central nervous system?	**Yes**	**No**	
	If "yes", please attach the results from the scan		

Section 8 - Paraplegia
This is defined as suffering Total and irreversible loss of the use of any two limbs, but excluding paraplegia caused by accidental, violent, external and visible means.

Please state the extent of the paraplegia (please tick)									
Irreversible		Permanent		Complete		Temporary		Partial	

State the limbs involved	
Please state the cause	

Section 9 - Stroke

This is defined as Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent motor deficit, and confirmed with appropriate clinical findings by a specialist neurologist.

For the above definition, the following are not covered:

- Transient ischaemic attack.
- Vascular disease affecting the eye or optic nerve.
- Migraine and vestibular disorders.
- Traumatic injury to brain tissue or blood vessels

Please state the specific type of incident	
Has this lasted for more than 24 successive hours?	
What was the cause?	
State the neurological sequelae present and how long did they last	
Is there any permanent neurological deficit?	

Section 10 – Medical Evidence/Reports

Please include copies of all the relevant reports and indicate below which reports are enclosed.

Histology	Radiology
Laboratory Test Results	ECG Tracings
Investigation/Procedure	Any other documentation which may be relevant

Section 11: Medical/Casualty Expense (if applicable)

The following documents will be required when claiming for medical expense:

1. An original invoice
2. any supporting documents
3. Receipts for accounts which the claimant has already settled

AUTHORISATION

Authorisation to be completed by the claimant or his/her legal representation.

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.

Signature of the Claimant or his/her legal representative	
Date	
Place	

Section 12: Broken Bones & Fractures (if applicable)
The following documents will be required when claiming:

1. An original invoice
2. X-rays
3. Receipts for accounts which the claimant has already settled

AUTHORISATION
Authorisation to be completed by the claimant or his/her legal representation.

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.

Signature of the Claimant or his/her legal representative	
Date	
Place	

DECLARATION
I hereby certify that the above statements are true in every respect.

Name:	
Qualifications:	
Signature:	
Date:	
Address:	
Telephone Number	
Practice Number	