

Claim form

Temporary & Permanent Disability

Please write in black ink and use block capital letters.

- Please return the completed claim form together with any enclosures to your insurance broker or to Chubb at the address shown
- The completion and/or submission of this claim form to us does not constitute an admission of your claim by Chubb Insurance Limited South Africa

Please ensure that the following documentation accompanies the claim form

- Confirmation of earning on company letterhead, signed by authorised representative of Company
- First Medical Report
- Final Medical Report stating the date on which the employee returned to work
- If the injury occurred on duty, then the claim is subject to the receipt of the COID act awards. Please supply details to Chubb.

Please ensure

- You fully complete every question **before** your doctor completes his statement
- Your attending doctor fully completes the statement

Personal details – to be completed by the policy holder

Name of Policy: Certificate/Policy Number:

Title: Full Name of Insured Person:

Date of Birth: Physical Address:

ID No:

Tel. No (Business):

Tel. No (Home): Fax No:

Cell phone No: Email:

Accident details

Please give exact date and time of the accident:

Date: _____ Time: _____ Am/Pm: _____

Title: _____ Full Name of Insured Person: _____ ID No: _____

Where did the accident occur?

How did the accident occur?

Full details of injuries sustained:

Have you previously claimed under this or a similar policy? Yes No If Yes, please give details:

If injured on duty has the claim been submitted to COID? Yes No

What was the injured person's occupation at the time of the accident?

Employment details

Please note this must be completed by the employer:

a) Is the claimant weekly / monthly remunerated? b) What is the average weekly / monthly earnings? c) What is the claimant's occupation?

d) Has the claimant been booked off work? Yes No If Yes, please provide dates:
From: _____ Returned: _____

Employer – it is important that you ensure you sign hereunder.

Signed:

Company Stamp:

Company designation: _____ Date: _____

Medical expenses

Is the claimant a member of a Medical Aid/Scheme? Yes No

Name and contact details of Medical Aid/Scheme: Scheme Name:

Membership Number:

Authorisation

Please note that this claim form will only be accepted if this declaration has been signed by the policyholder, claimant or authorised person.

I hereby warrant that the information given in this claim form is every respect complete, correct and true.

I authorise any medical practitioner, hospital or other person to provide Chubb Insurance Limited with any information they require relating to my medical history and the injury/illness to which the claim relates. I agree that this consent shall remain in force at all times, and that a photo-copy or fax for this declaration shall be accepted as original. I agree and accept that Chubb Insurance Limited may request additional information from any medical practitioner, hospital or any other person not specifically requested herein, on completion and submission of this form and any other documentation as submitted by me.

Signed by the claimant or his/her legal representative on this day of 20

Signature

Doctor's statement

This section must be fully completed by the patient's usual medical attendant – any fee for completion of this section is the responsibility of the insured person.

Title: Patients Full Name and Surname:

Date of Birth:

Height:

Weight:

Full details of injuries sustained:

Final diagnosis:

When did the patient first receive medical attention for the injuries sustained?

Has the patient ever suffered with this or any similar condition before the present episode?

Yes

No

If Yes, please give details including dates of treatments and consultations:

Can this be attributed to any other underlying condition?

Are you the patient's usual family doctor?

Yes

No

If No, please give name and address of usual doctor:

Disability

- | | | | |
|---|--|-----|----|
| a) On what date did incapacity commence? | b) Is the patient still incapacitated? | Yes | No |
| c) If Yes, when will the patient be able to return to work? | d) If No, when did incapacity cease? | | |
| e) Is the patient able to follow his/her usual occupation? | f) Will the injury in question avoid the claimant from following his/her usual occupation? | Yes | No |
| g) To what extent can permanent disability (if any) be ascribed to this injury alone? | | | |

Full Name of Doctor:

Practice Number:

Dr Signature:

Date:

Full Address:

Contact Number:

Data Privacy

We use personal information which you supply to us or, where applicable, to your insurance broker in order to write and administer this Policy, including any claims arising from it.

This information will include basic contact details such as your name, address, and policy number, but may also include more detailed information about you (for example, your age, health, details of assets, claims history) where this is relevant to the risk we are insuring, services we are providing or to a claim you are reporting.

We are part of a global group, and your personal information may be shared with our group companies in other countries as required to provide coverage under your policy or to store your information. We also use a number of trusted service providers, who will also have access to your personal information subject to our instructions and control.

You have a number of rights in relation to your personal information, including rights of access and, in certain circumstances, erasure.

This section represents a condensed explanation of how we use your personal information. For more information, we strongly recommend you read our user-friendly Master Privacy Policy, available here: <https://www.chubb.com/za-en/privacy-policy.html>. You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at: dataprotectionoffice.RSA@chubb.com.

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