WORKMEN'S COMPENSATION & COMMON LAW CLAIM FORM

IMPORTANCE NOTICE

REMEMBER: Incomplete answers will lead to delayed processing of your claim.

INSURED	Name_____ Tel. No._____ Address_____ Policy Number _____
CLAIMANT'S DETAILS	Claimant's Name_____ (If different from insured) Address_____ Tel_____Fax_____ Business/occupation_____ Position_____ Age _____Height_____Weight_____ Current pay_____per week/month/day_____ Amount being claimed_____

ACCIDENT **DETAILS**	Accident date_____Time _____Place_____ Please give particulars of accident, stating exactly how it happened_____ _____ _____ _____ _____ _____ _____ Were you engaged in your occupation when it happened? _____ Were there any witnesses to the accident? If so, please provide the details Witness _____ Address_____ Witness _____ Address_____
	What injuries did you sustain? Eye, leg, arm, left or right? _____ Who is the doctor attending to you? _____ Office Location? _____

	Is this your usual doctor? _____ How long have you been totally unable to attend to any portion of your profession or occupation? From _____To_____ How long have you been able to partially attend to your profession or occupation? From _____To_____ Are you entitled to benefits under any other insurance policy, society or club? _____ If so Give name of company/society and amount_____
MEDICAL **CERTIFICATE**	Notes for the Doctor Any fee for this certificate is payable by the insured_____ Total temporary disablement occurs when the patient is wholly unable to attend to all duties related to their profession or occupation. Partial temporary disablement begins when the patient is able to attend to any portion but not all of the occupation. 1. Name of patient_____ 2. Are you the usual medical attendant? _____ 3. How long have you know him/her? _____ 4. Please give details of injuries_____ _____ _____ _____ 5. When did you first attend to the patient for this current incident? _____ 6. Do the injuries seem consistent with the accident as described herein_____ 7. How long has the patient been totally disabled? _____ 8. How long has the patient been partially disabled? _____ 9. Has the patient any disease, disability or physical defect currently, apart from this accident? _____ 10. In your opinion, what is the percentage of disability based on the continental scale? _____

I DECLARE that these particulars are true and correct and undertake to forward immediately (and answered) any correspondence to this accident.

Date_____ Name _____

Signature of Insured _____
(and stamp)

IMPORTANT

1. **The doctor attending you must complete the medical certificate**

2. **Please provide us with the**
   - **Original medical receipts.**
   - **Copy of the pay Slip for the month preceding the accident.**
   - **Copies of the pay slips for the 12 months preceding the accident, if there are other benefits of a permanent nature besides the basic salary.**