Claim Form
Injury/Illness

Bryte Insurance Company Limited

A Fairfax Company

Registration number: 1965/006764/06 VAT number: 4530103581

Authorised Financial Services Provider No. 17703

15 Marshall Street, Ferreirasdorp, Johannesburg, 2001 PO Box 61489, Marshalltown 2107

Please complete this form in BLOCK CAPITALS and send it to your broker or to Bryte Insurance Company Limited.

The information that is sought herein is not intended to be an exhaustive list and Bryte accordingly reserves the right to request any further information deemed appropriate while investigating the claim.

Broker/Agent		Policy number	
Insured	Name and occupation		
	Address and (day) telephone number		
Insured person	Name and age		
	Business or occupation		
Relationship of injured person to insured	If employee, give annual earnings defined in the policy		
	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 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		

Insurers share information with each other regarding domestic policies and claims with a view to prevent fraudulent claims and obtain material information regarding the assessment of risks proposed for insurance. Please refer to the Consent Clause on the policy schedule for more details in this regard.

Payment method

You may select, for added security, for payment of any amount due to you to be made directly into a bank account. Please specify the name of the bank, branch, name of account and account number.

Name of bank _____ Branch _____

Name of account _____ Account number _____

Declaration/authorisation

I/We declare that the above particulars are true in every respect.

IMPORTANT

I hereby authorise any hospital, physician, or other person who has attended or examined me, to furnish to the Company, or its 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 photostatic copy of this authorisation shall be considered as effective and valid as the original.

Insured person's signature _____

Medical certificate

Must be completed by the doctor consulted

The patient must obtain, at his/her own expense, the following certificate from a duly qualified and registered medical practitioner. When the patient is fully recovered a doctor's certificate to that effect should be forwarded to the Insurers showing the periods of partial and total incapacity.

Name of patient _____ Height _____ Mass _____

1. When did you first treat the patient in consequence of the accident/illness sustained? _____
2. Are you still in attendance? ☐ Yes ☐ No
3. Are you the usual medical attendant of the patient? ☐ Yes ☐ No

   If yes, how long have you known him/her? _____

   _____
4. What was the cause of the accident/illness so far as known?
5. What injuries were sustained?

   (a) Region injured (if a hand or an arm, a foot or a leg, state whether it is the right or the left) _____

   (b) Are the symptoms from which he/she suffers due to:

   (i) the accident/illness alone, or _____

   (ii) are they traceable to any other cause? _____
6. Have you any reason to suspect that the patient was not perfectly sober at the time of the accident? ☐ Yes ☐ No
7. Is the patient now, or was he/she at the time of the accident/illness subject to or suffering from any illness or disease irrespective of the accident/illness for which the benefit is claimed? ☐ Yes ☐ No

   If yes, state the nature of same, and to what extent the recovery of the patient may be affected thereby _____

   _____
8. If you are the usual medical attendant of the patient, are you aware of anything in his/her previous medical history which might have contributed directly or indirectly to the occurrence of the accident/illness, or which may be likely to retard in any way recovery from it? ☐ Yes ☐ No

   If yes, state the nature of same _____

   _____
9. (a) Is the patient confined to bed, bedroom or house by your directions? ☐ Yes ☐ No

   (b) Has the patient at any time been so confined since the date of the accident/illness? ☐ Yes ☐ No

   If yes, give the dates _____

   _____
10. If still so confined, please state: (a) Your opinion as to the probable duration of such confinement; (b) Probable date of being able to resume some portion of usual business or occupation.

    (a) _____ (b) _____
11. Are you prepared to certify that the patient is TOTALLY disabled from attending to any portion of his/her business or occupation? ☐ Yes ☐ No

    (TEMPORARY TOTAL DISABLEMENT occurs when through accidental bodily injury or illness, the patient is immediately and continuously incapacitated for a specific period from attending to business or occupation of any kind).

    If patient has been able to attend to a PORTION only of his/her usual business or occupation, and if this still continues, please state since when, and also the probable date of recovery _____

    _____

    (TEMPORARY PARTIAL DISABLEMENT arises when the injury or illness does not wholly prevent the patient from attending to business, or when temporary total disablement ceases, and he/she can attend to some portion of his/her usual business or occupation, but not the whole).
12. If patient has recovered, please state date of recovery _____

GENERAL REMARKS _____

_____

_____

_____

_____

I certify that the aforegoing statements are correct.

Name _____

Qualifications _____

Address _____

Signature _____ Date _____