ACE Insurance Limited

Ground Floor, The Bridle, Hunts End Office Park
38 Wierda Road West, Wierda Valley
Sandton 2196
Tel: (011) 722-5700
Fax: (011) 783-0812
www.aceinsurance.co.za
myclaim@acegroup.com

ACE INSURANCE LIMITED CLAIM FORM – DREAD DISEASE CLAIM FORM

- THE COMPLETION AND/OR SUBMISSION OF THIS CLAIM FORM TO US DOES NOT CONSTITUTE AN ADMISSION OF YOUR CLAIM BY ACE INSURANCE LIMITED SOUTH AFRICA
- PLEASE RETURN THE COMPLETED CLAIM FORM TOGETHER WITH ANY ENCLOSURES TO YOUR INSURANCE BROKER OR TO ACE AT THE ADDRESS SHOWN.
- PLEASE ENSURE THAT THE DOCTORS STATEMENT IS COMPLETED AND IS ACCOMPANIED BY THE CLAIM FORM UPON SUBMISSION

1. INSURED DETAILS

Policy Number:	
Full Name of Insured:	
Physical Address:	
Business Tel No and contact person:	
Insurance Broker:	
E-mail:	
Contact person	

2. CLAIMANT/EMPLOYEES DETAILS (PLEASE NOTE THIS MUST BE COMPLETED BY THE EMPLOYER)

a) Full name of employee.	
b) Date of birth of employee.	
c) Identity number of employee	
d) Date of employment.	
e) What are the employee's annual earnings?	
f) Has the employee been booked off work for the illness being claimed for? If yes, from what date?	

3. CLAIMANT/EMPLOYEE (PLEASE NOTE THIS SECTION MUST BE COMPLETED BY THE EMPLOYEE / CLAIMANT)

What is the nature of your illness or disease?	
When did you become aware of your illness or disease?	
On what date was the diagnosis provided by the Doctor?	
Is this a re-occurring illness or disease?	
What is the name and address of the doctor you first consulted for this illness or disease?	

AUTHORISATION (PLEASE NOTE THAT THIS CLAIM FORM WILL NOT BE ACCEPTED IF THIS DECLARATION HAS NOT BEEN SIGNED BY THE EMPLOYEE/CLAIMANT)

I ____________________________________ hereby declare and warrant that the information given in this claim form is in every respect complete, correct and true.
I authorise any medical practitioner, hospital or other person to provide ACE Insurance Limited with any information they may require relating to the medical to which the claim relates. I agree that this consent shall remain in force at all times, and that a photo-copy or fax of this declaration shall be accepted as the original. I agree and accept that ACE 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 employee/claimant on this ____________________________ day of ______________________________________ 20__ _____.

Signed by the Insured Company/Employer on this ____________________________ day of ______________________________ 20_______

in the Capacity as the Insured Company's ____

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DOCTORS MEDICAL STATEMENT

THIS SECTION MUST BE FULLY COMPLETED BY THE DOCTOR CONSULTED MOST REGULARLY IN CONNECTION WIHT THE ILLNESS/DISEASE. ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE INSURED.

Patient's full Name and Surname:			(Mr,Mrs,Miss,Ms)		
Date of Birth:		Height:		Weight:	
Full details of illness/disease:					
Final diagnosis:					
1) On what date did the first symptoms appear?					
2) On what date did the patient become aware of the illness/disease?					
3) When did the patient first receive medical attention for the illness/disease?					
4) Has the patient ever suffered with this or any similar condition before the present episode?				Yes ☐	No ☐
5) If YES, please give details including dates of treatments and consultations:					
6) Kindly provide any other information that you may feel is relevant to assist us in assessing the Dread Disease claim:					
7) Are you the patient's usual doctor?	Yes ☐		No ☐		
If NO, please give name and address of the usual doctor:					
8) Is patient still incapacitated?	Yes ☐		No ☐		
9) If YES, when will patient be able to return to work?					
10) If NO, when did incapacity cease?					

SIGNATURE

Full name of Doctor:		Practice Number:	
Dr. Signature:		Date:	
Full Address:		Contact Number:	