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Claims
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Reg. No. 1973/008933/06

ACE Insurance Limited

ACE Insurance Limited Claim Form – Temporary & Permanent Disability Claim

- PLEASE USE BLACK INK AND BLOCK CAPITALS
- PLEASE RETURN THE COMPLETED CLAIM FORM TOGETHER WITH ANY ENCLOSURES TO YOUR INSURANCE BROKER OR TO ACE AT THE ADDRESS SHOWN.
- 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 ENSURE THAT THE FOLLOWING DOCUMENTS ACCOMPANY THIS CLAIM FORM (√)	
Confirmation of earnings 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 ACE Insurance.	☐

PLEASE ENSURE	
You fully complete every question **before** your doctor completes his statement	☐
Your attending doctor fully completes the statement	☐

1.1. PERSONAL DETAILS

Name of Policy:			
Certificate/Policy Number:			
Full Name of Insured Person:		(Mr,Mrs,Miss,Ms)	
Date of Birth:		I.D. no:	
Physical Address:			
Tel. no (Business):		Tel. no (Home):	
Fax. no:		Cellphone no:	
E-mail:			

1.2. ACCIDENT DETAILS

Please give exact date and time of accident	Date:		Time:		am/pm	
Full Name of Injured Person:				(Mr,Mrs,Miss,Ms):		
I.D. 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 a claim been submitted to COID	Yes ☐			No ☐		
What was the injured person's occupation at the time of the accident?						

1.3. 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 THAT YOU SIGN HEREUNDER.

Signed: ______________________________

Company designation: ______________________________

Date: ______________________________

Company Stamp:

1.4. MEDICAL EXPENSES

a) Is the claimant a member of a Medical Aid/Scheme?	
b) Name and contact details of Medical Aid	
c) Scheme name	
d) Membership Number	

1.5. AUTHORISATION

PLEASE NOTE THAT THIS CLAIM FORM WILL NOT BE ACCEPTED IF THIS DECLARATION HAS NOT BEEN SIGNED BY THE CLAIMANT OR AUTHORISED PERSON.

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 history of the deceased and the injury(ies) 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 claimant or his/her legal representative on this __________day of _______________20____.

Signature: _________________________

1.6. DOCTOR'S STATEMENT

THIS SECTION MUST BE FULLY COMPLETED BY THE DOCTOR CONSULTED. IN THE EVENT OF LIMB (INCL. HAND AND FOOT) INJURIES, PLEASE ATTACH A SKETCH INDICATING THE AREA EFFECTED. 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 injuries sustained:					
Final diagnosis:					
Where 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 family doctor:					
DISABILITY					
a) On what date did incapacity commence?					
b) Is patient still incapacitated?				Yes ☐	No ☐
c) If YES, when will 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:	