



Ground Floor, The Bridle
5700
Hunts End Office Park
0812
38 Wierda Road West
Wierda Valley,
Sandton

Tel : +27 11 722-
5700
Fax : +27 11 783-
P.O. Box 1192
Saxonwold
2132

ACE Insurance Limited

www.aceinsurance.co.za

CLAIM FORM

 **THIS SECTION IS TO BE COMPLETED BY THE POLICY HOLDER****

THANK YOU FOR NOTIFYING US OF YOUR CLAIM. PLEASE COMPLETE ALL QUESTIONS – IF ANY QUESTION(S) IS NOT APPLICABLE PLEASE STATE "N/A" PLEASE USE BLACK INK AND BLOCK CAPITALS. REMEMBER TO ATTACH A COPY OF YOUR IDENTITY DOCUMENT AND THAT OF THE INJURED PERSONS TO THIS FORM.

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

“Please note that 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”



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Signed:

Date:

 **DOCTORS STATEMENT:** THIS SECTION MUST BE FULLY COMPLETED BY THE DOCTOR CONSULTED. IN THE EVENT OF LIMB (INCL HAND & FOOT) INJURIES, THE ATTACHED SKETCH IS TO BE COMPLETED. ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE INSURED PERSON.

Patient's full Name & 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:

Are you the patient's usual doctor? YES / NO

If NO, please give name and address of usual doctor

Disability:

- On what date did incapacity commence?
- Is patient still incapacitated? YES / NO:
- If YES when will patient be able to return to work?
- IF NO when did incapacity cease?
- Is patient unable to follow usual occupation?

Signed:

Full name of Doctor:



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Date:

Full Address & contact number:

Please use validation stamp or complete in block capitals

Thank you for your assistance in completing this form!

PAYEES BANK DETAILS: When the claim has been approved you may have the payment credited direct to your Bank Account. This payment method is both speedier and safer than by cheque. If you would like to take advantage of this arrangement, please Complete the following:

Name of your Bank: _____	Branch sort Code: (from the top right hand corner of your cheque) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Address: _____ _____ _____	Account holder/name: _____
Code _____	Account no.: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

DECLARATION:

I declare that all the information given by me in this form is to the best of my knowledge and belief and is full, true and correct. I certify that the banking details are correct, failing which, ACE Insurance Limited are absolved against all direct losses, liabilities, suits, proceedings, costs, claims, demands, charges and expenses (including all legal and professional fees and disbursements) in respect thereof. I accept that it is my responsibility to inform ACE Insurance Limited of any changes in my banking details, failing which ACE Insurance Limited will accept no liability for changes which are not communicated by me.

👉 POLICY HOLDER – IT IS IMPORTANT THAT YOU ENSURE THAT YOU SIGN HEREUNDER.

Signed: _____	Date: _____
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Please list additional information and/or documentation attached to this claim:

👉 PLEASE ENSURE (✓)

- You fully complete every question **before** your doctor completes his statement
- You have enclosed all requested information/documentation
- You have signed the claim form



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Your attending doctor fully completes the statement.

As failure to do so will result in delay in handling your claim. Please return the completed claim form together with any enclosures to ACE at the Address shown.

Thank you for fully completing this form!