CYCLESURE
insurance consultants

Tel : 011 679 1559
Fax : 011 679 3823
e-mail: cyclesure@mweb.co.za
PO Box 4132, Cresta, 2118
71 David Street, Constantia Kloof, 1709

INJURY CLAIM FORM

www.cyclesure.co.za

BROKER / AGENT

Policy No.: _____ Claim No.: _____

INSURED

Name and business: _____

Address and (day) telephone No.: _____

INSURED PERSON

Name: _____ Contact No.: _____

Age: _____ Email: _____

INJURY / ILLNESS

When and where did accident occur Place: _____ Date: _____ Time: _____

Provide full particulars of the accident and nature of injuries: _____

PRE-EXISTING MEDICAL CONDITIONS

Provide full details of all pre-existing medical conditions: _____

WITNESS

Name and address: _____

DOCTOR

Name and address of doctor who attended to you: _____

Name and address of your usual doctor: _____

DISABLEMENT

Period of temporary disablement: From _____ To _____

Period of temporary partial disablement: From _____ To _____

Provide date normal occupation resumed: _____

Has any permanent disablement resulted? Give details _____

OTHER INSURANCES

Provide name of any other insurer with whom insured person is insured with: _____

PREVIOUS CLAIMS

Provide details of all claims made against insurers or in terms of the WCA by the insured person: _____

DECLARATION

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

Important: I hereby authorised the hospital, physician, or other person who has attended or examined me to furnish to the Company, or it's 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 at the original.

Signature of Insured	Capacity	Date

MEDICAL CERTIFICATE

Must be completed by doctor consulted

Name of patient: _____ Height: _____ Mass: _____

When did you first treat the patient in consequence of the accident/illness sustained? _____

_____

Are you still in attendance? _____

Are you the usual medical attendant of the patient, and if so, how long have you known him/her? _____

_____

What was the cause of the accident so far as known? _____

_____

What injuries were sustained? _____

_____

(A) region insured (if hand or arm, a foot, or leg, state whether it is the right or left) _____

(B) are the symptoms from which he/she suffers due to:

(i) the accident alone or _____

(ii) are they traceable to any other cause? _____

Have you any reason to suspect that the patient was not perfectly sober at the time of the accident? _____

_____

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 for which the benefit is claimed? If so state the nature of same, and to what extent the recovery of the patient my be affected thereby.

_____

_____

(a) is the patient confined to bed, bed-room or house by your description? _____

(b) has the patient at any time been so confined since the date of accident/illness? If so, give the dates: _____

_____

TEMPORARY TOTAL DISABLEMENT occurs when through accidental bodily injury, the patient and continuously incapacitate 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 occupation but not the whole.

If patient has recovered please state date of recovery _____

General remarks _____

_____

How is the current injury aggravated by pre-existing medical conditions _____

_____

_____

DECLARATION

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

Name: _____ Qualifications: _____ Signature: _____ Date: _____

Address: _____

Signature of the insured: _____ Capacity: _____ Date: _____