DEBILITY/DREAD DISEASE

safrican
Live the *Legacy*

To expedite your claim, kindly forward all claim documentation listed below:

1. Fully completed Debility Claim Form
2. Proof of bank account for the Claimant (cancelled cheque), if proceeds are payable into an account other than the collection account.
3. Proof of hospitalisation (if applicable)

Policy number | | | | | | | | | | | | | |

A. Details of claimant

Full names_____ Surname_____

Passport/ID number_____ Date of Birth_____

Where do we send you information?_____

Contact number_____

B. Details of Life Assured

Full names_____ Surname_____

Passport/ID number_____ Date of Birth_____

Where do we send you information?_____

Contact number_____

C. Bank Account details to which Policy Benefits must be paid

Account holder_____ Branch Code_____

Bank name_____ Branch_____

Account number_____ Type of account_____

D. Particulars of accident (Only required should impairment be due to an accident)

Accident Date _____ Accident Time _____

Name of Doctor consulted_____ First Consultation_____

Where did the accident take place_____

Describe how the accident happened_____

_____

Was the accident caused by wilful and / or unlawful acts or misconduct by the Assured? ☐ Yes ☐ No
If yes, please state details

_____

Will an enquiry be held? ☐ Yes ☐ No Will an enquiry be held? Y Y Y Y / M M / D D

Statement by Life Assured / Claimant where life assured is

I hereby notify Safrican Limited (hereinafter called The Company), of the above mentioned Accident Disability claim and confirm that all information given is true and correct. I acknowledge and agree acceptance of this statement and the supporting documentation shall not constitute or be considered as an admission by the company that any assurance on the life assured was in fact in force, nor waive the company's rights or defences.

_____ Y Y Y Y / M M / D D

Signature of Life Assured Date

E. Particulars of employment of Life Assured

Name of Business / Employer_____ Contact Number_____

Where did the accident take place_____

Postal Address / Email Address_____

_____ Postal Code_____

F. Employer's statement (This section must be completed by the employer of the person assured in support of a claim)

Full names_____ Surname_____

Passport/ID number_____ Date of Birth _____

Date of Accident_____ Date Returned to Work _____

Did employee present a medical certificate to employer? (if yes, copy of medical certificate to be attached) ☐ Yes ☐ No

Nature of Injuries Sustained _____

_____

G. Declaration by Employer

I, the undersigned, the employer, certify to the correctness of the information supplied above in respect of the death claim.

_____ _____

Signature of official Date

Did employee present a medical certificate to employer? (if yes, copy of medical certificate to be attached) ☐ Yes ☐ No

Nature of Injuries Sustained _____

_____

H. Medical Practitioner's statement (To be completed by Medical Practitioner)

Full names_____ Surname_____

Practice number_____ Contact number _____

Date of Accident_____ Date Returned to Work _____

Postal Address / Email Address_____

_____ Postal Code_____

Describe injuries sustained _____

_____

Has this injury occured before? ☐ Yes ☐ No

When were you first consulted by the insured? _____

Confirm nature of disablement ☐ Yes ☐ No

How long has patient been disabled from attending to his / her usual occupation? Y Y Y Y / M M / D D

Total Disability Period From Y Y Y Y / M M / D D To Y Y Y Y / M M / D D

Total Disability Period From Y Y Y Y / M M / D D To Y Y Y Y / M M / D D

Total Disability Period From Y Y Y Y / M M / D D To Y Y Y Y / M M / D D

How long do you expect the disablement to continue? (weeks / months / years) _____

Does the patient have any diseases, physical defects or has the patient contracted any diseases? ☐ Yes ☐ No

If yes, please state details _____

_____

To what extend will this influence recovery? _____

_____

Please indicate the applicable impairment as listed below:

Permanent loss or the loss of use of	☐ one limb	☐ two limbs
Permanent loss or the loss of use of	☐ one foot	☐ two feet
Permanent loss or the loss of use of	☐ one hand	☐ two hands
Permanent, total and irreversible loss of hearing	☐ in one ear	☐ in both ears
Permanent, total and irreversible loss of sight	☐ of one eye	☐ of both eyes

I. Declaration by Medical Practitioner

I, the undersigned, a registered medical practitioner, certify to the correctness of the information supplied above in respect of the death claim.

_____ _____

Signature of Medical Practitioner Date

Medical Practitioner Stamp

Contact us

Client Contact Centre: 010 880 5055
Physical address: Safrican House 21 9th Street Houghton Estate 2198
E-mail address: service@safrican.co.za