western
Rethink Insurance

GROUP PERSONAL ACCIDENT

Claim Form

INSURED

Name of insured	
Policy number	
Contact person	
Contact phone number	
Contact email address	

INCIDENT

Estimate		Injured on duty?	YES	NO
Date & time of incident		Death?	YES	NO
Date & time discovered		Is this incident covered under any other policy of insurance?	YES	NO
Date & time reported				
Place of loss				

POLICE

Place where reported	
Date of reporting	
Case number (if reported)	

EMPLOYEE

Name	
Contact phone number	
Contact email address	
Address	

Occupation	

TEMPORARY / PERMANENT DISABLEMENT

Expected dates off-duty	
Expected percentage of permanent disablement	

Please tick which of the following documents are attached

Doctor's certificate	
Confirmation of percentage disablement by doctor	
Letter of appointment	
First & Final Medical report	
Original medical accounts and medical aid statements	
Police plan and report on scene of accident	

IN CASE OF DEATH

Beneficiaries under the policy

Name	
Policy number	
Contact number	
Address	

Documents attached (please tick if attached)

Post Mortem report	
Inquest report	
Letter of executorship	

DECLARATION

I / we declare that to the best of my / our knowledge the above statements are true. I acknowledge that the information set out above is provided freely so that Western may process my claim and give effect to the terms and conditions contained in the policy wording. I herewith give my consent that Western may use this information, my personal information on record and additional information obtained from other sources in order to determine whether to accept or reject my claim and take all necessary steps ancillary thereto to give effect hereto.
I understand that I may be liable for output VAT in terms of section 8(8) of the VAT Act 89 of 1991.

Insured's signature	Capacity	Date

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T 021 914 0290
F 021 914 0290
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Gauteng
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