GUARDRISK
TAILORED RISK SOLUTIONS

GUARDRISK PERSONAL ACCIDENT CLAIM FORM

This form is required in order to assess a potential claim under a policy of insurance. Issue and completion of this form does not in any way imply, construe or admit liability by the Insurer. Only a fully completed form can receive our further consideration.

All claims to be reported to a&hclaims@guardrisk.co.za

Policy number

SECTION 1: INSURED

Insured name

Was the incident a motor vehicle accident? ◯ Yes ◯ No Is the claimant the driver? ◯ Yes ◯ No

Name of injured person ID number of injured person

Occupation of injured person Date of accident

Date of accident Time of accident Place of accident

When did the injury occur? ie; on duty, during business acitivity etc

SAPS/OAR case number

Give a detailed description of how the accident occurred.

The documentation listed below is required for this claim to be processed:

- A copy of the insured's ID
- A copy of the Injury on Duty (IOD) report detailing the injury that occurred during business hours or activities
- A copy of the accident report
- A copy of the OAR (police report) if the incident involves a motor vehicle accident
- Information about witnesses
- A copy of the injured party's salary slip

*NOTE:** It is not mandatory to submit all these documents at the time of filing the claim. You can provide them at a later stage to prevent any unnecessary delays.

SECTION 2: DEATH CLAIM (IF APPLICABLE)

Date of death DD | MM | YYYY

Place of death

The following documentation must be provided for this claim to be considered:

- Death Certificate
- Post Mortem Report
- Report for occupational related death
- Police Accident Report if death was due to a motor vehicle accident
- Police Reference number if death is the subject of a criminal investigation
- Copies of any newspaper clipping or eye witness statements that may be available

NOTE: It is not necessary to have all these documents when submitting the claim. These documents can be forwarded at a later stage to avoid any unnecessary delays.

SECTION 3: DISABILITY CLAIM *(IF APPLICABLE)*

Give full details of the injuries sustained by the claimant

Name of attending doctor

Practice number

Tel no.

Address

Please state the period which the claimant was totally disabled from attending to his/ her usual occupation

Date DD | MM | YYYY

Please state the date upon which he/ she resumed light duties DD | MM | YYYY

Has any permanent disablement resulted from this accident

If yes, please give details

SECTION 4: MEDICAL EXPENSE

The following documents will be required when claiming for medical expense:

- An original medical aid account proving admission into hospital and discharge dates is required when claiming under this section
- Receipts for accounts which the claimant has settled already

SECTION 5: TEMPORARY INCOME REPLACEMENT (TTD)

The following documents will be required when claiming for Temporary Income Replacement (TTD)

- Confirmation of earnings
- Medical report
- If involved in a motor accident, a copy of the police/accident report is required

Give the full details of the injuries sustained by the claimant

Name of attending doctor

Practice number

Tel no.

Address

I hereby authorise any hospital, physician, or individual who has treated me to provide the insurer or my legal representatives with all information concerning any injuries, illnesses, medical history, consultations, prescriptions, or treatments, including copies of my hospital or medical records. I agree that a photocopy or fax of this authorization will be considered as valid as the original.

I affirm that all responses I have given in this claim form are accurate in every respect.

Full name of insured/claimant

Signature

SECTION 6: HOSPITALISATION BENEFIT

The following documents will be required when claiming for the hospitalisation benefit

- Original medical records and account proving admission into hospital and discharge dates

I hereby authorise any hospital, physician, or individual who has treated me to provide the insurer or my legal representatives with all information concerning any injuries, illnesses, medical history, consultations, prescriptions, or treatments, including copies of my hospital or medical records. I agree that a photocopy or fax of this authorization will be considered as valid as the original.

I affirm that all responses I have given in this claim form are accurate in every respect.

Full name of insured/claimant

Signature

This section is to be completed by the salaries or Human Resources department

Full name of insured/claimant

Full time employee

Please confirm the disability and dates of absence from work stated in this claim are correct

Disability

Date of absence

State fully the nature of the claimant's occupation and daily duties

Occupation

Daily duties

AUTHORISATION

Authorisation to be completed by the claimant or his/ her legal representarion

I hereby authorise any hospitalc, physician or any other person who treated me , to furnish the insurer or legal representatives with all information with regard to any injury, sickness, medical history, consultation, prescription or treatment including copies of all my hospital or medical reports. I agree that a photostat/ fax copy of this authorisation shall be accepted as the original. I declare that the answer given by me in this claim form are true in every aspect.

Signature of the claimant or his/her legal representation

Date

Place

EMPLOYER CERTIFICATE

This section is to be completed by the salaries or human resources department

Full name of insured/claimant

Signature

Is the claimant a full time permanent employee

Please confirm the disability and dates of absence from work stated in this claim form are correct

Disability

Date of absence

State fully the nature of the claimant's occupation and daily duties

Occupation

Daily duties

In the case of Injury on Duty (10D)please confirm and provide the following

Was this 10D reported?

MEDICAL CERTIFICATE

This section is to be completed by the doctor consulted

The claimant must obtain, at his/her own expenses, the following certificate from a duly qualified and registered medical paractitioner who treated him/her for his/her injuries. When the claimant is fully recovered, a doctor certificate to that effect must be forwarded to the insurer showing the periods of partial and total incapacity.

MEDICAL CERTIFICATE

Full name of insured/claimant

Signature

When you were first consulted by the claimant in connection with his/her injuries

Are you still in attendance

What was the cause of the accident so far as known

What injuries were sustained

Please state the exact cause and nature of the disability and any other important factors connected therewith

Does the present disability relate in any way to previous injuries or pre-existing conditions or illness
If yes, please explain

Is the patient now or was he/she at the time of the accident subject to or suffering any illness or disease irrespective of the accident for which the benefit is claimed?
If so, state the nature of it, and to what extent the recovery of the patient may be effected thereby

Is the patient temporarily or permanently disabled from attending to any portion of his/her usual business of occupation
If yes, please explain

If the patient has fully recovered, please state the date of recovery

IN THE EVENT OF SERIOUS ILLNESS CONFIRM AND PROVIDE THE FOLLOWING

Was this a newly diagnosed illness ◯ Yes ◯ No Date of diagnosis

Type of illness

Have you claimed, from this policy, for any of these illnesses before? ◯ Yes ◯ No

Type of illness Date of diagnosis

Date of payment When did symptoms first appear?

When did you first consult a doctor for this condition?

Name of Doctor Contact number of Doctor

Name of Hospital Address of Hospital

Details of medical assistance sought in the last 5 years (minor illnesses such as colds and flu may be omitted)

AUTHORISATION

Authorisation to be completed by the claimant or his/ her legal representarion

I hereby authorise any hospitalc, physician or any other person who treated me , to furnish the insurer or legal representatives with all information with regard to any injury, sickness, medical history, consultation, prescription or treatment including copies of all my hospital or medical reports. I agree that a photostat/ fax copy of this authorisation shall be accepted as the original. I declare that the answer given by me in this claim form are true in every aspect.

Signature of the claimant or his/her legal representation

Date

Place

SERIOUS ILLNESS MEDICAL CERTIFICATE

This section is to be completed by the doctor consulted

The claimant must obtain, at his/ her own expenses, the following certificate from a duly qualified and registered medical practitioner who treated him/ her for his/her injuries. When the claimant is fully recovered, a doctor's certificate to that effect must be forwarded to the insurer showing the periods of partial and total incapacity

SERIOUS ILLNESSMEDICAL CERTIFICATE

Patient's name Age of patient

Are you the patients usual medical attendant? Yes No

If yes, please give details of the patients medical/ surgical history for the last 12 months prior to hospitalization

When did the patient first become aware of the symptoms?

Has the patient suffered from this disease in the past? Yes No

If yes, please give details

When was medical advice sought?

Do you know of any other hereditary disease in the patients family? Yes No

If yes, please provide details

Do you know of any factors regarding past or present health, habits or lifestyle which may have contributed to any health problems?
If yes, please provide details

Select the applicable illness (x)

Cancer	Motor Neuron Disease	Parkinson's Disease	Multiple Sclerosis
Coronary Artery Surgery	Alzheimer's	Heart Valve Surgery	Blindness
Heart Attack	Coma	Paraplegia	Major organ transplant

SECTION 2: CANCER

This is defined as a malignant tumor positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

The term malignant tumor includes leukemia, lymphoma and sarcoma. The following conditions are excluded from this definition:

- All cancers in situ and all pre-malignant conditions
- All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- All skin cancers, other than malignant melanoma that has been histologically classified as having invasion beyond the epidemic (outer layer skin)

State the site and extent of the neoplasm

Is it malignant or non-malignant? Has staging been carried out? ◯ Yes ◯ No

If yes, please give details (please comment on invasion of metastases)

SECTION 3: CORONARY ARTERY SURGERY

This is defined as the actual undergoing, on the advice of a consultant surgeon, of coronary artery bypass surgery to correct stenosis or occlusion in the coronary arteries but excluding angioplasty, keyhole surgery and other non surgical techniques such as laser procedures.

State the type of procedure done Date procedure performed

SECTION 4: HEART ATTACK

- This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by two of the following three criteria:
- Compatible clinical symptoms
- Characteristic ECG changes which can be either of the following:
  - New pathological Q-waves as defined below
  - ST-segment and T-wave changes indicative of myocardial ischaemia that may progress to myocardial infarction, as defined below, but only when accompanied by raised cardiac markers as described below
- Pre-intervention raised cardiac markers
  - Trop T greater than 1,0ng/ml
  - Trop I greater than 0,5ng/ml
  - CK-MB mass greater than two times the normal values in acute presentation phase or
  - Total CPK elevation of greater than two times the normal value, with at least 6% being CK-MB

The evidence must show a definite acute myocardial infarcation. Other acute coronary syndromes, including but not limited to angina, are not covered by this definition.

SECTION 4: HEART ATTACK

For purposes of this definition, new pathological Q-waves mean the following:

- Any Q-waves in leads V1through V3, Q-wave greater than or equal to 30ms (0.03s) in leads I, II, AVL, AVF, V4 V5 or V6.
- The Q-wave changes must be present in any two contigiuous leads, and be grater than or equal to 1mm in depth ECG changes indicative of myocardial ischaemia that may progress to myocardial infarcation, mean the following:
- Patients with ST- segment elevation
  - New orpresumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to0.2mV in leads V1, V2 or V3 and more or equal to 0.01mV in other leads. Contiguity in the frontal plane is defined by the lead sequence AVL, I , inverted AVR, II , AVF, III
- Patients without ST-segment elevation:
  - ST-segment depression
  - T-wave abnormalities only

State the type and extent of the infarction

Is there a history of chest pain? ◯ Yes ◯ No

State the new ECG changes and the date done

Has an ECG been done before? ◯ Yes ◯ No

If yes, please give details

When was the test done and what were the cardiac enzyme levels

State the following UP levels, if done and the dates

CPK		**AST**	
MBCK		**ILDH**	

SECTION 5: KIDNEY FAILURE

This is as chronic end stage failure of both kidneys to function, as a result of which regular dialysis is necessary

Is there chronic irreversible failure of both kidneys ◯ Yes ◯ No

Give the dates and results of the kidney function tests done

Has regular dialysis been instituted? ◯ Yes ◯ No

Give the dates and results of the kidney function tests done

SECTION 6: MAJOR ORGAN TRANSPLANT

This is defined as which shall mean the actual undergoing as a recipient of a transplant of the heart, liver, pancreas, bone marrow or at least one of the kidney's or lungs.

What organ was replaced?

What was the underlying disease?

For how long was the disease present?

What was the source of replacement?

SECTION 7: MULTIPLE SCLEROSIS

This is defined as a definite diagnosis of multiple sclerosis by a neurologist. There must be current clinical impairment of motor or sensory function of an EDSS scale 3.0 or more, which must have persisted for a continuous period of at least 6 months. Benign multiple sclerosis will not be covered.

Has the following neurological investigations been done?

Lumber puncture ◯ Yes ◯ No

Please provide details

Evoked visual responses ◯ Yes ◯ No

Please provide details

MRI scan ◯ Yes ◯ No

Please provide details

Was there evidence of any lesion of the central nervous system? ◯ Yes ◯ No

Please provide details

SECTION 8: PARAPLEGIA

This is defined as suffering total and irreversible loss of the use of any two limbs, but excluding paraplegia caused by accidental, violent, external and visible means.

Please state the extent of the paraplegia (please tick)

Irreversible ◯	Permanent ◯	Compete ◯	Temporary ◯	Partial ◯

State the limbs involved

Please state the cause

SECTION 9: STROKE

This is defined as death of brain tissue due to inadequate blood supply or hemorrhage within the skull resulting in permanent motor deficit, and confirmed with appropriate clinical findings by a specialist neurologist.

For the above definition, the following are not covered:

- Transient ischaemic attack
- Vascular disease affecting the eye or optic nerve
- Migraine and vestibular disorders
- Traumatic injury to brain tissue or blood vessels

Please state the specific type of incident

Has this lasted for more than 24 successive hours? ◯ Yes ◯ No

What was the cause?

State the neurological sequelae present and how long did it last?

Is there any permanent neurological deficit?

SECTION 10: MEDICAL EVIDENCE / REPORTS

Please include copies of all the relevant reports and indicate which reports are enclosed.

Histology ☐	Radiology ☐	ECG Tracings ☐
Laboratory Test Results ☐	Investigation/ Procedure ☐	Any other documentation which may be relevant ☐

SECTION 11: MEDICAL/CASUALTY EXPENSE (IF APPLICABLE)

The following documents will be required when claiming for medical expense:

- An original invoice
- Any supporting documents
- Receipts for accounts which the claimant has already settled

I hereby authorise any hospitalc, physician or any other person who treated me , to furnish the insurer or legal representatives with all information with regard to any injury, sickness, medical history, consultation, prescription or treatment including copies of all my hospital or medical reports. I agree that a photostat/ fax copy of this authorisation shall be accepted as the original. I declare that the answer given by me in this claim form are true in every aspect.

Signature of the claimant or his/her legal representation

Date

Place

SECTION 12: BROKEN BONES AND FRACTURES (IF APPLICABLE)

The following documents will be required when claiming for medical expense:

- An original invoice
- Any supporting documents
- Receipts for accounts which the claimant has already settled

I hereby authorise any hospitalc, physician or any other person who treated me , to furnish the insurer or legal representatives with all information with regard to any injury, sickness, medical history, consultation, prescription or treatment including copies of all my hospital or medical reports. I agree that a photostat/ fax copy of this authorisation shall be accepted as the original. I declare that the answer given by me in this claim form are true in every aspect.

Signature of the claimant or his/her legal representation

Date

Place

INFORMATION SHARING | CONSENT OF INSURED

Your personal information is valued by us and we respect your constitutional right to privacy. We are committed to processing your personal information in accordance to relevant legislation. We are bound by the terms and provisions of the Protection of Personal Information Act No 4 of 2013 ("POPI") regarding the acquisition, usage, retention, transmission and deletion of your personal information.

Please be advised that your personal information herein provided by you or collected is for the primary purpose of assessing and processing your claim in respect of the loss/damage, to the insured property, which you have suffered. The information submitted on this document is subject to verification and shall be authenticated using lawful procedures. Your information shall be used in complete lawful form and manner to execute all tasks required for efficient assessment and processing of your claim.

Your information shall be kept confidential; however, we shall disclose it to certain third parties in accordance with the purpose of collection. The third parties may include our service providers, agents, claim handlers, investigators, credit bureaus, Insurance Crime Bureau and other insurers.

The lawful sharing of your personal information with other Insurance companies is for the following reasons:

- to ensure that not more than one claim has been made for the same damage/loss to property arising from the same set of facts
- to verify that claims information match what was provided when insurance cover was taken out
- if necessitated to act as a basis for investigating claims when our recorded information is incorrect or when we suspect fraudulent activity.

Guardrisk undertakes to attend to all that is necessary to detect and prevent fraud thus protecting our clients. Guardrisk, therefore shall utilise and disclose your personal information where essential to substantiate your claim. All third parties are fully aware and understand the purpose for which the information is being transmitted to them. No third party including Guardrisk shall use your personal information for any other purpose unless expressly consented to by you. We have implemented security measures to safeguard your personal information against damage loss and unauthorised access.

Any party to whom your personal information is being disclosed to is also bound by confidentiality and the provisions of POPI, whereby security measures are enforced to safeguard your personal information.

In terms of POPI we are required to collect and process information which is authentic and accurate. You may amend, update, change or correct your personal information processed by us. You may request to view your personal information held by us and we shall make same available to you. We also store your information for the period prescribed by the Applicable Laws.

DECLARATION

You hereby give consent to Guardrisk to process, use, share and retain your personal information for its designated purpose. You fully understand the purpose for which your personal information has been collected and you duly consent thereto. You further consent to the lawful sharing and disclosure of your information and understand the necessity of same. You indemnify Guardrisk from any claims resulting from disclosures made with your consent.

You are fully aware and understand your rights duties and obligations to furnish Guardrisk with true and accurate information and your duty to advise Guardrisk of any changes to your personal information timeously. The said consent is given to Guardrisk with the necessary legal capacity, voluntarily and free of intimidation and duress of any form.

I/ we hereby declare the aforegoing particulars to be true in every respect.

Full name of insured/claimant		Signature	
Full name of driver *(where applicable)*		Signature	