Accident Cash Benefit
Claim Form

CLAIMING

The submission of this claim does not automatically constitute an admission of liability under this policy.

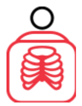
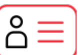
This Accident Cash Benefit Claim form is to be completed in full - please give us as much information as you can so that we can conclude the assessment of your claim speedily.

Please also give us ALL supporting documents that we've asked you for, otherwise we can't assess the claim. If you don't give us all the documents within 30 days, it may lead to the Insurer rejecting your claim.

DOCUMENTS YOU MUST GIVE US

Hospital	• Hospital statement

DOCUMENTS THAT CAN FURTHER HELP YOUR CLAIM

	• All X-Ray/CT Scan/ECG/Ultrasound Reports.
	• Copy of the Police Report/Incident Report including the case number. This document is available from the SAPS where the Accident/Incident was reported.
	• Copy of the Patient's valid driver's licence. (Only where the Insured was the driver of the motor vehicle at the time of the MVA)
	• Copy of the Patient's Blood Alcohol Test Results/Report. (Only where the Insured was the driver of the motor vehicle at the time of the MVA)

Completed Claim Forms and All Supporting documentation can be sent via email or upload to:

Email: tuclaims@iua.co.za

CSS: https://selfservice.iua.co.za/

PERSONAL DETAILS

POLICYHOLDER DETAILS

FULL NAME		SURNAME	
ID NUMBER		POLICY NUMBER	
TELEPHONE NUMBER		EMAIL ADDRESS	
CELL NUMBER			

PERSON COMPLETING THE FORM

FULL NAME		SURNAME	
ID NUMBER		POLICY NUMBER	
DATE OF BIRTH	D D M M Y Y Y Y	RELATIONSHIP TO THE INJURED PARTY	
TELEPHONE NUMBER		EMAIL ADDRESS	
CELL NUMBER			

DETAILS OF THE PATIENT

FULL NAME		SURNAME	
ID NUMBER		NAME OF EMPLOYER	
DATE OF BIRTH	D D M M Y Y Y Y	TELEPHONE NUMBER OF EMPLOYER	

RESIDENTIAL ADDRESS		ADDRESS OF EMPLOYER	
POSTAL CODE		POSTAL CODE	

DETAILS OF CLAIM

DIAGNOSIS							
ICD 10 CODE							
HOSPITAL NAME							
DATE ADMITTED	D D M M Y Y Y Y	TIME	H H : M M				
DATE DISCHARGED	D D M M Y Y Y Y	TIME	H H : M M				
TYPE OF WARD		WARD NAME					
PATIENT'S HOSPITAL NUMBER		TELEPHONE EXTENSION					
WAS PATIENT CONFINED TO ICU		YES		NO	DATE FROM D D M M Y Y Y Y	DATE TO	D D M M Y Y Y Y
WAS HOSPITALISATION A RESULT OF AN ACCIDENT/INJURY		YES		NO			
DATE OF ACCIDENT/INJURY	D D M M Y Y Y Y						
NATURE OF ACCIDENT/INJURY							
POLICE STATION REPORTED		CASE NUMBER					
DID HE/SHE HAVE ANY TREATMENT FOR THIS DISEASE/ILLNESS IN THE LAST 12 MONTHS		YES		NO			
IF YES, STATE DATE	D D M M Y Y Y Y						

WAS HOSPITALISATION CONNECTED IN ANY WAY TO A MENTAL DISEASE OR DISORDER, USE OF ALCOHOL, THE INFLUENCE OF ANY DRUG NOT ADMINISTERED ON THE ADVICE OF A DOCTOR, INJURY OR ILLNESS CAUSED THROUGH INTENTIONAL SELF-INFLICTION?		YES		NO
IF YES, GIVE DETAILS				

IN THE CASE OF A FEMALE, WAS HOSPITALISATION DUE TO PREGNANCY, CHILDBIRTH, MISCARRIAGE, ABORTION OR COMPLICATIONS THEREOF?		YES		NO
IF YES, GIVE DETAILS				

PAYMENT INSTRUCTIONS
BANK ACCOUNT DETAILS THAT THE INSURER IS TO PAY THE BENEFIT INTO:

ACCOUNT HOLDERS NAME ______________________________

NAME OF BANK ______________________________

TYPE OF ACCOUNT [CURRENT] [SAVINGS]

ACCOUNT NUMBER ______________________________

BRANCH CODE ______________________________

DECLARATION BY ATTENDING DOCTOR

I, HEREBY CERTIFY THAT THE PERSON HOSPITALISED, AS NAMED IN THIS FORM, WAS SUFFERING FROM THE INJURIES/ILLNESS REFERRED TO IN THIS FORM AND I KNOW OF NO CIRCUMSTANCES, OTHER THAN THE AFOREMENTIONED, WHICH MIGHT AFFECT THE ASSESSMENT OF THE CLAIM, IF ANY, IN RESPECT OF THE PERSON INSURED.

SIGNATURE OF DOCTOR	HOSPITAL STAMP	SIGNED AT	
		DATE	D D M M Y Y Y Y
		HOSPITAL NAME	
		DOCTOR NAME	
		TELEPHONE NUMBER	

FICA DECLARATION BY INSURED/CLAIMANT

The Unlimited must abide by FICA regulations. Due to these regulations we need you to answer a few questions. If you do not answer these questions, we may not be able to move forward with your claim.

In the past 12 months have you held a political position in South Africa or elsewhere, for example, a member of Parliament? ________

Do any of your family members or friends hold political positions? ________

Do you, your family or friends own or have a senior job at a Company that provides goods or services to Parliament, Cabinet or the Courts? ________

If the answer to any of the above is yes, please provide details on the position held: ______________________________

____

DECLARATION BY INSURED/CLAIMANT

I, the undersigned, being the Insured/Claimant:

- undertake to provide The Unlimited, the Insurer or IUA Business Solutions (Pty) Ltd (**the Companies**) with all the documents they need to assess this claim;
- confirm that all the information I have provided in this form is true and complete, and that I have not withheld any information that could impact the outcome of this claim;
- authorise the Companies to access and process all my personal information to assess the claim, including hospital and other medical records. I also authorise the Companies to process the personal (including medical) information of other people whose interests are protected by the policy (for example, my spouse or children). In this regard, I as well as my spouse if applicable, consent to the Companies processing the personal information of my children for the purposes of assessing this claim;
- authorise all the doctors and medical facilities which examined and treated me/the patient/deceased to provide all information about this claim to the Companies. In this regard, I waive all protections afforded to me by any law, custom or professional etiquette which prevent a doctor or medical facility from disclosing a patient’s personal (including medical) information. I agree that this waiver shall remain in force until cancelled in writing;
- indemnify the Companies against any and all damages, losses, claims and costs made against the Companies by people whose information I have authorised them to process, such as my spouse or adult dependants.

	Signed at:

Signature of Policyholder/Person completing the form

Date D D M M Y Y Y Y

Witness 1 Name/Surname

Witness 2 Name/Surname

Accident Cash Benefit
Police Report

To be completed by the investigating officer at the police station where the incident/accident was reported. This reportis required for an accident cash benefit claim and will be kept confidential.
Please ensure that all questions are answered in full.

Policy number

PARTICULARS OF THE PATIENT

PATIENT

FULL NAME														SURNAME	
ID NUMBER														OCCUPATION	

PARTICULARS OF POLICE CASE

POLICE STATION WHERE INCIDENT/ACCIDENT WAS REPORTED																	
TELEPHONE NUMBER																	
NAME OF INVESTIGATING OFFICER										RANK							
DATE, TIME AND PLACE OF WHERE INCIDENT/ACCIDENT TOOK PLACE	DATE	D	D	M	M	Y	Y	Y	Y	TIME	H	H	:	M	M		
	PLACE																
MAGISTERIAL DISTRICT																	
CASE NUMBER																	

INCIDENT/ACCIDENT DETAILS

WAS THE PATIENT INVOLVED IN A MOTOR VEHICLE ACCIDENT?																YES		NO
DATE AND TIME OF ACCIDENT	TIME	H	H	:	M	M	DATE	D	D	M	M	Y	Y	Y	Y			
WAS THE PATIENT		THE DRIVER		A PASSENGER		A PEDESTRIAN												
IF THE PATIENT WAS THE DRIVER, WAS AN ALCOHOL TEST DONE AT THE SCENE OF THE ACCIDENT?																YES		NO
IF THE PATIENT WAS THE DRIVER, DID HE/SHE POSSESS A VALID DRIVER'S LICENCE?																YES		NO
WAS AN ILLEGAL ACT COMMITTED?																YES		NO
IF YES, PLEASE ELABORATE:																		

PLEASE ATTACH A COPY OF THE BLOOD/SPECIMEN ALCOHOL CONTENT REPORT

WAS THE PATIENT INVOLVED IN AN:		ASSAULT		SHOOTING		STABBING		RAPE		OTHER
	IF OTHER, PLEASE SPECIFY:									
WAS THE PATIENT AN INNOCENT BYSTANDER?		YES		NO	IF YOUR ANSWER IS NO, PLEASE GIVE DETAILS					

PLEASE GIVE A BRIEF DESCRIPTION OF THE CIRCUMSTANCES OF THE INCIDENT

LEGAL DETAILS

INQUEST

HAS AN INQUEST BEEN HELD		YES		NO	NAME OF COURT	
WILL AN INQUEST BE HELD		YES		NO	DATE OF INQUEST	D D M M Y Y Y Y
INQUEST REFERENCE NUMBER					INQUEST NUMBER	

CRIMINAL CHARGES

HAVE CRIMINAL PROCEEDINGS BEEN INSTITUTED?		YES		NO	NAME OF COURT	
WILL CRIMINAL PROCEEDINGS BE INSTITUTED?		YES		NO	DATE OF TRIAL	D D M M Y Y Y Y
TRIAL REFERENCE NUMBER					TRIAL NUMBER	
WHAT WAS THE CHARGE?					WHO WAS CHARGED?	

I, the undersigned, ____
hereby declare that all the information provided herein and as completed by myself is true and correct, and furthermore that no relevant information has been withheld which may impact on the outcome of this claim.

	Signed at:

Signature of Investigating Officer

Date D D M M Y Y Y Y

Official stamp: