CYCLESURE
INSURANCE CONSULTANTS
an Authorised Financial Services Provider | Infinite Cover and Dedication - Enjoy the Ride

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INJURY CLAIM FORM

PERSONAL DETAILS

Title: _____ Name: _____ Surname: _____

ID number: _____ Cellular number: _____

Occupation: _____ Tel No. (Work): _____

Tel No. (Home): _____ Tel No. (Home): _____

_____ Code: _____ Email address: _____

INJURY / ILLNESS

- When and where did the incident occur? Date: _____ Time: _____ Place: _____
- Provide full particulars of the accident and nature of injuries: _____

_____

PRE-EXISTING MEDICAL CONDITIONS

Provide details of all pre-existing medical conditions: _____

_____

WITNESS

Name: _____ Surname: _____

Contact number: _____ Address: _____

DOCTOR

- Name and addreess of doctor who attended to you: _____

_____

- Name and addreess of your usuale 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: _____

INJURY CLAIM FORM

OTHER INSURANCES

Provide name of any other insurer with whom insure 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 reprentative, 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 as the original.

We care about your privacy. In order to provide you with our service, we and our service providers have to process the personal information you provide us with by completing this form. We will treat this information with caution and we have put reasonable security measures in place to protect it.

Signature of Insured: _____ Capacity: _____ Date: _____

Infinite cover and dedication...enjoy the ride!

INJURY CLAIM FORM

MEDICAL CERTIFICATE (Must be completed by doctor consulted)

Name and surname 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 as 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 if 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 may 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 specific period from attending to business or ocupation of any kind.

If patient has been able to attend to a portion only of his / her usual business or occupation, ad if this still continues please state 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 is recovered, please state date of recovery: _____

General remarks: _____

_____

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

INJURY CLAIM FORM

DECLARATION

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

Name: _____ Qualification: _____ Signature: _____ Date: _____

Address: _____

Signature of Insured: _____ Capacity: _____ Date: _____

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Hollard.