ONE

INJURY CLAIM FORM

Policyholder	
Policy Number	

DETAILS:

Injured person			
ID Number		E-mail Address	
Tel No (H)		Tel No (W)	
Fax Number		Cell Number	
Residential Address			
		Code	
Business or Occupation		VAT Number	

RELATIONSHIP OF INJURED PERSON TO INSURED:

If employee give annual earnings defined in the policy	
If other, specify relationship	

INJURY:

When and where did incident occur?		Place			
		Time		Date	
Give full particulars of the incident and nature of injuries					

WITNESS:

Witness Name		Cell Number	
Residential Address			
		Code	

ONE Insurance Underwriting Managers (Pty) Ltd Reg No. 1996/008987/07
Authorised Financial Services Provider FSP8783 VAT No. 4370160501

OMART INSURE
OLD MUTUAL ALTERNATIVE RISK TRANSFER INSURE LIMITED

ONE

DOCTOR:

Name of doctor who attended you	
Address of doctor who attended you	
Name of your usual doctor	
Address of your usual doctor	

DISABLEMENT:

Period of temporary total disablement				
Period of temporary partial disablement				
Give date normal occupation resumed				
Has any permanent disablement resulted?	Yes		No	
If so give details				

OTHER INSURANCE:

Give name of any other insurer with whom injured person is insured	

PREVIOUS CLAIMS:

Give details of all claims made against insurers or in terms of COIDA by the insured person	

PROCESSING NOTICE

This Notice is a summary of our Privacy Policy which describes how ONE, as responsible party, process your personal information as data subject, in terms of the Protection of Personal Information Act, 4 of 2013, (POPIA). For the full version please click here or contact us for a copy.

Your personal information will be collected and processed to enable ONE to give effect to your insurance policy in the processing of your claim. The processing of your personal information is mandatory to enable ONE to investigate the validity of your claim, eliminate any duplication of the claim and to quantify a valid claim. Should you choose to not provide us with your personal information we will not be able to process your claim.

Your personal information may be shared internally with employees required to process the claim and externally with ONE's affiliated companies, companies who supply services to ONE such as legal, administrative, and investigative services and other insurers. All third parties will only be provided with the personal information required for the purpose the information is being processed.

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ONE has high levels of security in place to protect your personal information and require all third parties to comply with the standards as set out in POPIA.

You are entitled to ask ONE as responsible party for the particulars of personal information held as well as identity of any person who had access to such personal information. You may also request ONE to correct any incorrect information and to delete personal information under certain circumstances.

DECLARATION

I declare that the answers given, whether in my handwriting or not, are true and complete to the best of my knowledge and belief and will form the basis of the claim.

I understand that any misrepresentation or non-disclosure of material facts shall render the claim null and void. Note: a material fact is one which may influence the assessment or acceptance of your claim. If you are in doubt as to the relevance of any information, please give details.

I understand that by signing this form, I consent to the processing of personal information for its designated purpose in terms of the POPI Act.

I confirm that I will assist ONE or their representatives in any way relevant to assess, validate and finalise this claim. I confirm that this document was completed freely and without intimidation or coercion by any party.

I confirm that the affixed signature is mine or that of my/our appointed authorised representative and that the signature binds the insured in all material respects.

Signed at: _____ Date: _____

Full Name: _____ ID Number: _____

_____ _____

Signature Designation

Required documents for Temporary Total Disability, Temporary Partial Disability and Emergency Medical Expenses.

- **Completed claim form**
- **Medical Reports**
- **Medical Accounts**
- **Resumption Report**
- **Proof of Earnings**
- **Copy of the Police Report**
- **Injury on Duty – claim submitted to COID/Workman's Compensation Commissioner.**

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DOCTOR'S STATEMENT

This section must be fully completed by the patient's usual medical attendant – any fee for completion of this section is the responsibility of the insured person.

Title		Full Name of Patient			
Height		Weight		Patient Occupation	
Full details of the illness/injury					
Final diagnosis					
When did the patient first recieve medical attention for injury/illness:					
Has the patient ever suffered with this or any similar condition before the present episode			Yes		No
If Yes, please give details including dates of treatments and consultations					
Can this be attributed to any other underlying condition?			Yes		No
Are you the patient's usual family doctor?			Yes		No
If No, please give name and address of usual doctor:					

DISABILITY

On what date did incapacity commence?					
Is the patient still incapacitated?			Yes		No
If Yes, when will the patient be able to return to work?					
If No, when did incapacity cease?					
Is the patient able to follow his/her usual occupation?					
Will the inujury in question avoid the claimant from following his/her usual occupation?			Yes		No
To what extent can permanent disability (if any) be ascribed to this injury alone?					
Full Name of Doctor		Practice Number			
Doctor Signature		Date			
Contact Number					
Full Address					