

STUDENT EMERGENCY ASSIST CLAIM FORM

POLICYHOLDER DETAILS

Policyholder				
Policy Number				
Contact Person	Cell Number			
Email	Tel Number (W)			
Business Address				
		Code		
Has the Principal been advised of this incident? Yes No				
Was the Emergency Call Centre used? Yes No				

SCHOOL BODY DETAILS

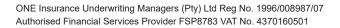
Name of sc	hool	
Day Tel		Contact person
Reference I	No:	

PATIENT INFO

Name and Surname				
Tel Number (H)		Cell Number		
Email				
Home Address				
			Code	
Postal Address				
Code				
Grade		Date of Birth		
Amount Claimed (Attach Invoices related to date of incident only) R			R	

DETAILS OF INCIDENT

Date of incident				
Address where incident occurred				
Give full particulars of the incident and nature of injuries. (Use separate sheet if necessary)				
Provide a short statement from teacher on duty				





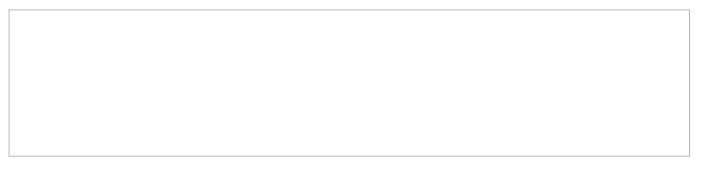


Hospital / doctor where treated	
Name and address of doctor who a	ttended
Name and address of your usual do	octor

MEDICAL AID DETAILS

Who is the main member of the Medical Aid Scheme									
Name of medical sche	eme			Membership number					
Details of parent/guardian									
Contact details	Tel			Fax		E-mail			
Details of parent/guardian employer									
Contact details	Tel			Fax		E-mail			
Medical Aid Statements relating to claims attached				Yes		No			
If No please obtain and submit									

ADDITIONAL INFORMATION



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.





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



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