OLDMUTUAL

BOTSWANA

INJURY/ILLNESS CLAIM FORM

Unit 8, Plot 64511, Fairgrounds,
Gaborone, Botswana
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Please print in block letters using black or blue ink.

Policy number

Claim number

Broker/Agent

DETAILS OF INSURED

Name

Surname

Identity number

VAT registration number

Address

Day telephone number

Occupation

DETAILS OF INSURED PERSON

Name

Age years

Business or Occupation

If employee, give annual earnings defined in the policy P

Relationship to the insured

If other, specify relationship

DETAILS OF INJURY/ILLNESS

Where did the accident occur/illness commence?

When did the accident occur/illness commence? Date Y Y Y Y M M D D Time

Give full particulars of the accident and nature of the injuries or the name of the illness.

DETAILS OF WITNESS

Name

Address

DETAILS OF DOCTORS

Name of attending doctor

Address

Name of usual doctor

Address

DETAILS OF DISABLEMENT

Period of temporary total disablement From Y Y Y Y M M D D To Y Y Y Y M M D D

Period of temporary partial disablement From Y Y Y Y M M D D To Y Y Y Y M M D D

Give date normal occupation resumed Date Y Y Y Y M M D D

Please supply details if any permanent disablement has resulted?

DETAILS OF OTHER INSURANCES/PREVIOUS CLAIMS

Name of an other insurer with whom the insured person is insured

Please supply details of all claims made against insurers or in terms of WCA by the insured person.

AUTHORISATION/DECLARATION BY INSURED PERSON

I/We hereby authorise any hospital, physician, or other person who has attended or examined me/us, to furnish the company, or its authorised representative, 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.

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

Signature of Insured Person

Date Y Y Y Y M M D D

TO BE COMPLETED BY THE CONSULTING DOCTOR

The Patient must obtain, at his own expense, the following certificate from a duly qualified and registered Medical Practitioner.
When the Patient is fully recovered a doctor's certificate to that effect should be forwarded to the Insurers showing the periods of partial and total incapacity.

Name of patient

Height Mass

1. When did you first attend upon the Patient in consequence of the Accident/Illness sustained? Y Y Y Y M M D D
2. Are you still in attendance? YES NO
3. Are you the usual medical attendant of the patient? YES NO
   If "YES", how long have you known him/her? years
4. What was the cause of the Accident/Illness so far as known?
5. What injuries were sustained?
   (a) Region injured (if a hand or an arm, a foot or a leg, state whether it is the right or the left)
   (b) Are the symptoms from which he/she suffers due to:
   (i) The Accident/Illness alone, YES NO OR (ii) Are they traceable to any other cause? YES NO
6. Have you any reason to suspect that the Patient was not perfectly sober at the time of the Accident? YES NO
7. 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/Illness for which the benefit is claimed? YES NO
   If "YES", state the nature of same, and to what extent the recovery of the Patient may be affected thereby.
8. If you are the usual Medical Attendant of the Patient, are you aware of anything in his/her previous medical history which might have contributed directly or indirectly, to the occurrence of the Accident/Illness, or which may be likely to retard in any way recovery from it? YES NO
9. (a) Is Patient confined to bed, bedroom, or house by your directions? YES NO
   (b) Has Patient at any time been so confined since the date of the Accident/Illness? YES NO
   If "YES", please supply dates. Y Y Y Y M M D D
10. If still so confined, please state:
    (a) Your opinion as to the probable duration of such confinement.
    (b) Probable date of being able to resume some portion of usual business or occupation: Y Y Y Y M M D D
11. Are you prepared to certify that the Patient is TOTALLY disabled from attending to any portion of his/her business or occupation? YES NO
    (TEMPORARY TOTAL DISABLEMENT occurs when through accidental bodily injury or illness, the Patient is immediately and continuously incapacitated for a specific period from attending to business or occupation of any kind).
12. If Patient has been able to attend to a PORTION only of his/her usual business or occupation, and if this still continues, please state since when and also probable date of recovery.
    Disablement date Y Y Y Y M M D D Recovery date Y Y Y Y M M D D
    (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 or occupation, but not the whole).
13. If Patient has recovered, please state date of recovery. Recovery date Y Y Y Y M M D D

GENERAL REMARKS

I certify that the aforegoing statements are correct.

Name

Qualifications

Address

Signature

Date Y Y Y Y M M D D