DELPHI GROUP INSURANCE BROKERS CAPE (PTY) LTD

REGISTERED INTERNATIONAL INSURANCE BROKERS AND CORPORATE

TO : _____

NAME OF CLUB : _____

DIVISION : _____

TEL NO OF CLUB : _____

FAX NO OF CLUB : _____

EMAIL ADDRESS OF CLUB : _____

NAME OF PLAYER : _____

POSITION PLAYED : _____

DATE OF INJURY : _____

NATURE OF INJURY : _____

TEL NO OF PLAYER : _____

NAME OF EMPLOYER : _____

TEL NO OF EMPLOYER : _____

NAME OF MEDICAL AID : _____

The attached claim form is issued strictly without prejudice or admission of liability

No claim shall be considered where the claim form is not received within 30 days of the injury or event occurring. All information as requested must be completed / supplied.

All claim matters must be strictly communicated to the following references only :

Tel no. (021) 914 1700 **Fax no. (021) 914 1740** **Email : lelanie@delphisure.com / soccer@delphisure.com**

Postal address: **Delphisure Group**
P.O. Box 3388
Tygerpark
7536

Date issued : _____ **Signature :** _____

The following Medical Certificate must be completed at the expense of the claimant in a duly qualified and registered medical practitioner

MEDICAL ATTENDANT'S CERTIFICATE

Name of Patient in full : _____

Did this patient ever in the past, visit you, professionally relating to this injury? If so, please supply dates and injuries under your attention: _____

_____

Were the symptoms from which she/he has been suffering due to the accident alone or were they traceable to or aggravated by any other causes? _____

_____

Give the dates during which the patient has been totally incapacitated.

NOTE : Temporary total incapacitation occurs when through accident the insured is immediately and continuously rendered completely unable to pursue his ordinary occupation or to attend to any business affairs whatsoever.

The medical attendant is particularly requested to complete (a) , (b) and (c) separately

Whilst

a) Confined to bed From _____ To _____ inclusive
b) Confined to the house From _____ To _____ inclusive
c) Not Confined to the house From _____ To _____ inclusive

NOTE : Temporary partial incapacitation arises when the injury does not wholly prevent the insured from pursuing his ordinary occupation or attending to his usual business affairs.

If the patient has been able to attend to a portion only of his usual business or occupation, please give the dates which he has been partial incapacitated: From _____ To _____ inclusive

From what date did you sanction a return to full work? _____

I certify that I have, by personal examination, satisfied myself that the insured is suffering from the injury described above.

Date: _____ Signature of Practitioner: _____

Qualification: _____ Name of Medical Practitioner: _____

Address: _____ Code: _____

Cell no. _____ Tel no. _____ Fax no. _____

WITNESS / REFEREE STATEMENT

I hereby declare that the claim documentation, supporting paperwork and particulars are true and correct and to the best of my knowledge and belief.

Dated: This _____ day of _____ 20 _____

Signature: _____

Certificate to be completed and signed by the Eye Witness and if possible by the person under whose direction the workman was working at the time of the accident

I hereby declare that I was present when the Accident occurred to _____
on the _____ day of _____ 20 _____
in the manner above stated that it was caused by which was * was not his willful act, and that he was * was not under the influence of intoxicating liquor or drugs at the time.

Name (PRINT) : _____

Address : _____

_____

Tel no. : _____

Cell no. : _____

Occupation : _____

Date : _____

*** Strike out which is not applicable**

ACCIDENT DEPARTMENT CLAIM FORM

Particulars for adjusting **CLAIM FOR COMPENSATION** in respect of the Accident which occurred to :

_____ On _____ 20 ____

Name of Claimant in full : _____

Home address : _____

_____

Present Business or occupation : _____

State the nature of the accident in respect of which you now claim : _____

_____

Have you been totally unable to attend to any portion of your business ? _____

Give the date of such total capacity :

Whilst

a) Confined to bed From _____ To _____ inclusive
b) Confined to the house From _____ To _____ inclusive
c) Not Confined to the house From _____ To _____ inclusive

Give the dates during which you were able to pursue only portion of your usual occupation:

From _____ To _____ inclusive

On what date were you able to attend to the whole of your usual business or occupation?

On the _____ day of _____ 20 _____

Have you ever suffered from an accident of a similar nature to the one under consideration? _____

_____

Are you now insured against accident in any other office? If so, give the name of the office, and / or have you submitted a claim against RAF Workman's Compensation Medical Aid or any other institution? If so, give the name of the company: _____

I hereby declare that the foregoing particulars are true in every respect and that I have not abstained from my ordinary occupation longer than it has been absolutely necessary in consequence of the accident which occurred on the

_____ Day of _____ 20 _____ Signature: _____

A MEDICAL CERTIFICATE MUST BE SUPPLIED IN SUPPORT OF EVERY CLAIM