Bryte

Claim Form
Injury/Illness

Bryte Insurance Company Limited

A Fairfax Company

Please complete this form in BLOCK CAPITALS and send it to your broker or to Bryte Insurance Company Limited.

The information that is sought herein is not intended to be an exhaustive list and Bryte accordingly reserves the right to request any further information deemed appropriate while investigating the claim.

Broker/Agent		Policy number	
Insured	Name and occupation		
	Address and (day) telephone number		
Insured person	Name and age		
	Business or occupation		
Relationship of injured person to insured	If employee, give annual earnings defined in the policy		
	If other, specify relationship		
Injury/illness	When and where did accident occur or illness commence?	Date	Time
		Place	
	Give full particulars of the accident and nature of injuries or the name of the illness		
Witness	Name and address		
Doctor	Name and address of doctor who attended you		
	Name and address of your usual doctor		
Disablement	Period of temporary total disablement	From	To
	Period of temporary partial disablement	From	To
	Give date normal occupation resumed	Date	
	Has any permanent disablement resulted? Give details		
Other insurances	Give name of any other insurer with whom insured person is insured		
Previous claims	Give details of all claims made against insurers or in terms of the WCA by the insured person		

Insurers share information with each other regarding domestic policies and claims with a view to prevent fraudulent claims and obtain material information regarding the assessment of risks proposed for insurance. Please refer to the Consent Clause on the policy schedule for more details in this regard.

Payment method

You may select, for added security, for payment of any amount due to you to be made directly into a bank account. Please specify the name of the bank, branch, name of account and account number.

Name of bank ______________________ Branch ______________________

Name of account ______________________ Account number ______________________

Declaration/authorisation

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

IMPORTANT

I hereby authorise any hospital, physician, or other person who has attended or examined me, to furnish to 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.

Insured person's signature ______________________

March 2023

Medical certificate

Must be completed by the doctor consulted

The patient must obtain, at his/her 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 treat the patient in consequence of the accident/illness sustained? ______________________

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? ______________________

   ____

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, or ______________________

      (ii) are they traceable to any other cause? ______________________

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

   If yes, state the nature of same ______________________

   ____

9. (a) Is the patient confined to bed, bedroom or house by your directions? ☐ Yes ☐ No

   (b) Has the patient at any time been so confined since the date of the accident/illness? ☐ Yes ☐ No

   If yes, give the dates ______________________

   ____

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.

    (a) ______________________ (b) ______________________

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).

    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 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 or occupation, but not the whole).

12. If patient has recovered, please state date of recovery ______________________

GENERAL REMARKS ____

____

____

____

____

I certify that the aforegoing statements are correct.

Name ____

Qualifications ____

Address ____

Signature ______________________________ Date ______________________________

Damage to Property POPI Act

Your personal information is valued by us and we respect your constitutional right to privacy. We are committed to processing your personal information in accordance to relevant legislation. We are bound by the terms and provisions of the Protection of Personal Information Act No 4 of 2013 ("POPI") regarding the acquisition, usage, retention, transmission and deletion of your personal information.

Please be advised that your personal information herein collected is for the primary purpose of assessing and processing your claim in respect of the loss/damage, to the insured property, which you have suffered. The information submitted on this document is subject to verification and shall be authenticated using lawful procedures. Your information shall be used in complete lawful form and manner to execute all tasks required for efficient assessment and processing of your claim.

All information acquired herein is relevant to the stated purpose. Your personal information may also be collected for certain mandatory purposes, please consult our *Consent to Process Personal Information* for a list of same.

Your information shall be kept confidential; however, we shall disclose it to certain third parties in accordance with the purpose of collection. The third parties may include our service providers, agents, claim handlers, investigators and other insurers.

The lawful sharing of your personal information with other Insurance companies is for following reasons:

a. to ensure that not more than one claim has been made for the same damage/loss to property arising from the same set of facts

b. to verify that claims information match what was provided when insurance cover was taken out

c. if necessitated to act as a basis for investigating claims when our recorded information is incorrect or when we suspect fraudulent activity.

Bryte undertakes to attend to all that is necessary to detect and prevent fraud thus protecting our clients. Bryte, therefore shall utilise and disclose your personal information where essential to substantiate your claim.

All third parties are fully aware and understand the purpose for which the information is been transmitted to them. No third party including Bryte shall use your personal information for any other purpose unless expressly consented to by you.

We have implemented high level security measures to safeguard your personal information against damage loss and unauthorised access. Any party to whom your personal information is been disclosed to is also bound by confidentiality and the provisions of POPI, whereby security measures are enforced to safeguard your personal information. The third parties we contract with are required to abide by our standards of safety, security and privacy.

In terms of POPI we are required to collect and process information which is authentic and accurate. You may amend, update, change or correct your personal information processed by us. You may request to view your personal information held by us and we shall make same available to you.

You hereby give consent to Bryte to process, use, share and retain your personal information for its designated purpose. You fully understand the purpose for which your personal information has been collected and you duly consent thereto. You further consent to the lawful sharing and disclosure of your information and understand the necessity of same.

You are fully aware and understand your rights duties and obligations to furnish Bryte with true and accurate information and your duty to advise Bryte of any changes to your personal information timeously. The said consent is given to Bryte with the necessary legal capacity, voluntarily and free of intimidation and duress of any form.

Signed at ____on the ________ day of ___________________________________ 20 ________

Signature of policyholder ____

Registration number: 1965/006764/06 VAT number: 4530103581
Licensed insurer and an authorised FSP (17703)
Rosebank Towers, 5th Floor, 15 Biermann Avenue, Rosebank, 2196