

### Bryte Insurance Company Limited

A Fairfax Company

Registration number: 1965/006764/06 VAT number: 4530103581

Licensed insurer and authorised FSP (17703)

15 Marshall Street, Ferreirasdorp, Johannesburg, 2001 PO Box 61489, Marshalltown 2107

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			
Agreement number			
Participant	Name/occupation or business		
	Address and day telephone number		
Covered person	Name and age		
	Business or occupation		
Relationship of injured person to participant	If employee, give annual earnings defined in the agreement		
	If other, specify relationship		
Injury/illness	When and where did accident occur or illness commence?  Give full particulars of the accident and nature of injuries or the name of the illness	Date	Time
		Place	
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 covered person is covered		
Previous claims	Give details of all claims made against insurers or in terms of the WCA by the covered person		

Companies share information with each other regarding personal lines agreements and claims with a view to prevent fraudulent claims and obtain material information regarding the assessment of risks proposed for cover. Please refer to the Consent Clause on the statement of cover 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 complete details below:		
	Name of bank		
	Branch		
	Name of account		
	Account number		

I/We declare the foregoing particulars to be 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.

Covered person's signature \_\_\_\_\_ Capacity \_\_\_\_\_ Date \_\_\_\_\_ 20 \_\_\_\_\_

**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 company 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 foregoing statements are correct.

Name \_\_\_\_\_

Qualifications \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_