



***ASSISTERE CLAIM FORM***

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| **This form is required in order to assess a potential claim under a policy of insurance. Issue and completion of this form does not in any way imply, construe, or admit liability by the Insurer. Only a fully completed and signed claim form can receive our further consideration. All claims to be reported to:**  Telephone 011 669 1202  E-mail [a&hclaims@guardrisk.co.za](mailto:a&hclaims@guardrisk.co.za)  Postal address P.O.Box 786015, Sandton, 2146 |

**Section 1: General**

|  |  |
| --- | --- |
| Name of Insured |  |
| Name of Injured employee |  |
| Employee’s Occupation |  |
| ID Number |  |
| Date, time & place of accident |  |
| Is this an Injury during business hours/activities |  |
| SAPS & OAR case number |  |
| Give a detailed description of how the accident occurred. |  |

The following documentation must be provided for this claim to be considered: -

**NOTE:** It is not necessary to have all these documents when submitting the claim. These documents can be forwarded at a later stage to avoid any unnecessary delays.

1. Copy of the injured`s ID.
2. Copy of the IOD Report of an accident in the event of an Injury during business hours/activities
3. Copy of the OAR (police report) in the event of a motor vehicle accident.
4. Details of witnesses.
5. Copy of the injured’s salary slip

**Section 2: Death Claim (if applicable)**

|  |  |
| --- | --- |
| Date & Place of death |  |
| State the exact cause of death and any important factors connected therewith. |  |

The following documentation must be provided for this claim to be considered: -

**NOTE:** It is not necessary to have all these documents when submitting the claim. These documents can be forwarded at a later stage to avoid any unnecessary delays.

1. Death Certificate
2. Post Mortem Report
3. Report for occupational related death
4. Police Accident Report if the death was due to a motor vehicle accident
5. Police Reference number if death is the subject of a criminal investigation
6. Copies of any newspaper clipping or eye witness statements that may be available

***SECTION 2B* Final Rest *submit:***

1. ***Certified Death Certificate***
2. ***Post Mortem***
3. ***Incident Report***

**Section 3: Disability Claim**

|  |  |
| --- | --- |
| Give full details of the injuries sustained by the claimant |  |
| Name of the attending doctor |  |
| Practice Number |  |
| Tel No |  |
| Address |  |
| Please state the period which the claimant was totally disabled from attending to his/her usual occupation | |
| From |  |
| Please state the date upon which he/she resumed light duties |  |
| Has any permanent disablement resulted from this accident, if yes, please give details: |  |

**Section 4: Medical Expense (if applicable)**

The following documents will be required when claiming for medical expense:

An original Medical Account proving admission into hospital and discharge dates is required when claiming under this section

Receipts for accounts which the claimant has already settled

**AUTHORISATION**

Authorisation to be completed by the claimant or his/her legal representation.

I hereby authorise any hospital, physician or any other person who treated me, to furnish the Insurer or the legal representatives with all information with regard to any injury, sickness medical history, consultations, prescription or treatment including copies of all my hospital or medical reports. I agree that a photostat / fax copy of this authorisation shall be accepted as the original. I declare that the answers given by me in this claim form are true in every respect.

|  |  |
| --- | --- |
| Signature of the Claimant or his/her legal representative |  |
| Date |  |
| Place |  |

**EMPLOYER CERTIFICATE**

**This certificates is to be completed by the Salaries or Human Resource Department**

|  |  |
| --- | --- |
| Full Name of Claimant |  |
| Is the claimant a full time permanent employee |  |
| Please confirm the disability and dates of absence from work stated in this claim form are correct |  |
| State fully the nature of the claimant’s occupation and daily duties |  |

**In the event of an IOD please confirm and provide the following**

|  |  |
| --- | --- |
| Was this IOD reported? |  |
| Do you have a COID claims number |  |

**Please note that the following documents must be submitted as soon as possible:**

1. Employer’s report of an accident or disease (Wcl1 0r Wcl2 )
2. First Medical Report (Wcl4)
3. Progress or Final Medical Report (Wcl5)
4. Resumption Report (Wcl6)

**Declaration by Employer**

I hereby warrant the truth of all particulars on this form in every respect and declare that all conditions of this insurance have been complied with:

|  |  |
| --- | --- |
| Signature: |  |
| Date: |  |
| Capacity |  |
| Company Stamp |  |

**MEDICAL CERTIFICATE**

|  |
| --- |
| This certificate is to be completed by the doctor consulted |

The claimant must obtain, at his/her own expenses, the following certificate from a duly qualified and registered medical practitioner who treated him/her for his/her injuries. When the claimant is fully recovered, a doctor’s certificate to that effect must be forwarded to the Insurer showing the periods of partial and total incapacity.

|  |  |
| --- | --- |
| Full name of patient |  |
| When were you first consulted by the claimant in connection with his/her injuries |  |
| Are you still in attendance |  |
| What was the cause of the accident so far as known |  |
| What injuries were sustained |  |
| Please state the exact cause and nature of the disability and any important factors connected therewith |  |
| Does the present disability relate in any way to previous injuries or pre-existing conditions or illness |  |
| If yes, please explain |  |
| Is the patient now or was he/she at the time of the accident subject to or suffering from any illness or disease irrespective of the accident for which the benefit is claimed? |  |
| If so, state the nature of it, and to what extent the recovery of the patient may be effected thereby |  |
| Is the patient temporarily or permanently disabled from attending to any portion of his/her usual business or occupation |  |
| If yes, please explain. |  |
| Please state any information not already mentioned which is relevant to the assessment of any permanent disability arising from the accident |  |
| If the patient has fully recovered, please state the date of recovery |  |

**In the event of Serious Illness confirm and provide the following**

|  |  |  |
| --- | --- | --- |
| Was this a newly diagnosed Illness? | **Yes** | **No** |
| Date of Diagnosis |  | |
| Type of Illness |  | |
| Have you claimed, from this policy, for any of these illnesses before? | **Yes** | **No** |
| **If yes, please give full detail:** | |
| Type of Illness |  |
| Date of Diagnosis |  |
| Date of Payment |  |
| When did the symptoms first appear? |  | |
| When did you first consult a doctor for this condition? |  | |
| Name, Address and Telephone Number of the doctor consulted |  | |
| Name, Address and Telephone Number of the hospital(s) where you have been treated for this condition |  | |
| Details of medical assistance sought in the last 5 years (minor illnesses such as colds and flu may be omitted) |  | |
| Name, Address and Telephone Number of your usual doctor |  | |

### Authorisation to be completed by the claimant or his/her legal representative

I hereby authorise any hospital, physician or any other person who has treated me to furnish the Insurer or its legal representatives with all information with regard to any injury, sickness medical history, consultations, prescriptions or treatments including copies of all my hospital or medical records. I agree that a photostat/fax copy of this authorisation shall be accepted as the original. I declare that the answers given by me in this claim form are true in every respect.

Signature of the Claimant or his/her legal representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SERIOUS ILLNESS MEDICAL CERTIFICATE**

|  |
| --- |
| This certificate is to be completed by the doctor consulted |

The claimant must obtain, at his/her own expenses, the following certificate from a duly qualified and registered medical practitioner who treated him/her for his/her injuries. When the claimant is fully recovered, a doctor’s certificate to that effect must be forwarded to the Insurer showing the periods of partial and total incapacity.

**(Please complete sections 1 & 10 and the appropriate one of sections 2 to 9)**

## Section 1 – General

|  |  |  |
| --- | --- | --- |
| Patient’s Name |  | |
| Age |  | |
| Are you the patient’s usual medical attendant? | **Yes** | **No** |
| If “yes”, please give details of the patient’s medical/surgical history for the last 12 months prior to hospitalisation | |
| When did the patient first become aware of the symptoms? |  | |
| When was medical advice sought? |  | |
| Has the patient suffered from this disease in the past? | **Yes** | **No** |
| If “yes”, please give details | |
| Do you know of any hereditary disease in the patient’s family? | **Yes** | **No** |
| If “yes”, please give details | |
| Do you know of any factors regarding past or present health, habits or lifestyle which may have contributed to any health problems? | **Yes** | **No** |
| If “yes”, please give details | |

|  |  |  |
| --- | --- | --- |
| Do you know of any hereditary disease in the patient’s family? | **Yes** | **No** |
| If “yes”, please give details | |

**Select the applicable illness (*x*)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Cancer** |  | **Motor Neuron Disease (resulting in permanent symptoms)** |  | **Paraplegia** |  |
| **Coronary Artery Surgery** |  | **Alzheimer’s** |  | **Multiple Sclerosis (with persisting symptoms)** |  |
| **Heart Attack** |  | **Coma (resulting in permanent neurological complications):** |  | **Blindness** |  |
| **Stroke (resulting in permanent symptoms)** |  | **Parkinson’s Disease** |  | **Major Organ Transplant** |  |
| **Kidney Failure** |  | **Heart Valve Surgery** |  |  |  |

#### Section 2 – Cancer

This is defined as a malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.The following conditions are excluded from this definition:

* All cancers in situ and all pre-malignant conditions.
* All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
* All skin cancers, other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

|  |  |
| --- | --- |
| State the site and extent of the neoplasm |  |
| Is it malignant or non-malignant? |  |

|  |  |  |
| --- | --- | --- |
| Has staging been carried out? | **Yes** | **No** |
| If “yes”, please give details  Please comment on invasion of metastases | |

#### Section 3 – Coronary Artery Surgery

This is defined as the actual undergoing, on the advice of a consultant surgeon, of coronary artery bypass surgery to correct stenosis or occlusion in the coronary arteries but excluding angioplasty, keyhole surgery and other non-surgical techniques such as laser procedures.

|  |  |
| --- | --- |
| State the type of procedure done and date perform |  |
| What were the events predisposing to surgery |  |

**Section 4 – Heart Attack**

This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by two of the following three criteria:

* Compatible clinical symptoms
* Characteristic ECG changes, which can be either of the following:
  + New pathological Q-waves as defined below, or
  + ST-segment and T-wave changes indicative of myocardial ischaemia that may progress to myocardial infarction, as defined below, but only when accompanied by raised cardiac markers as described below.
* Pre-intervention raised cardiac markers:
  + Trop T greater than 1,0 ng/ml, or
  + Trop I greater than 0,5 ng/ml, or
  + CK-MB mass greater than two times the normal values in acute presentation phase, or
  + Total CPK elevation of greater than two times the normal values, with at least 6% being CK-MB.

The evidence must show a definite acute myocardial infarction. Other acute coronary syndromes, including but not limited to angina, are not covered by this definition.

For purposes of this definition, new pathological Q-waves mean the following:

Any Q-wave in leads V1 through V3, Q-wave greater than or equal to 30 ms (0.03s) in leads I, II, AVL, AVF, V4, V5or V6. The Q-wave changes must be present in any two contiguous leads, and be greater than or equal to 1mm in depth ECG changes indicative of myocardial ischaemia that may progress to myocardial infarction, mean the following:

* Patients with ST-segment elevation:
  + New or presumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to 0.2mV in leads V1, V2,or V3, and more or equal to 01.mV in other leads. Contiguity in the frontal plane is defined by the lead sequence AVL, I, inverted AVR, II, AVF, III.
* Patients without ST-segment elevation:
  + ST-segment depression.
  + T-wave abnormalities only

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| State the type and extent of the infarction | | | | |  | | | | | | |
| Is there a history of chest pain? | | | | |  | | | | | | |
| State the new ECG changes and the date the ECG done | | | | |  | | | | | | |
| Has an ECG ever been done before? | | | | | **Yes** | | | | **No** | | |
| If “yes”, please give details | | | | | | |
| When was the test done and what were the cardiac enzyme levels? | | | | |  | | | | | | |
| **CPK** |  | **AST** |  | **MBCK** | |  | **CK** |  | | **LDH** |  |
| State the following UP levels, if done and the dates | | | | |  | | | | | | |

#### Section 5 – Kidney Failure

#### This is defined as Chronic end stage failure of both kidneys to function, as a result of which regular dialysis is necessary.

|  |  |  |
| --- | --- | --- |
| Is there chronic irreversible failure of both kidneys |  | |
| Give the dates and results of the kidney function tests done |  | |
| Has regular renal dialysis been instituted | **Yes** | **No** |
| Please state the frequency of dialysis |  | |

#### Section 6 – Major Organ Transplant

This is defined as which shall mean the actual undergoing as a recipient of a transplant of the heart, liver, pancreas, bone marrow or at least one of the kidneys or lungs.

|  |  |
| --- | --- |
| What organ was replaced? |  |
| What was the underlying disease? |  |
| For how long was the disease present? |  |
| What was the source of the replacement? |  |

#### Section 7 – Multiple Sclerosis

This is defined as a definite diagnosis of multiple sclerosis by a neurologist. There must be current clinical impairment of motor or sensory function of an EDSS scale 3.0 or more, which must have persisted for a continuous period of at least 6 months. Benign multiple sclerosis will not be covered.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Has the following neurological investigations been done? | Lumber puncture | **Yes** | | **No** |
| If “yes”, please give the date the procedure was done and attach the results | | | |
| **Evoked visual responses** | **Yes** | | **No** |
| If “yes”, please give the date the procedure was done and attach the results | | | |
| **Evoked auditory responses** | **Yes** | | **No** |
| If “yes”, please give the date the procedure was done and attach the results | | | |
| MRI scan | **Yes** | | **No** |
| If “yes”, please give the date the procedure was done | | | |
| Was there evidence of any lesion of the central nervous system? | **Yes** | | **No** | |
| If “yes”, please attach the results from the scan | | | |

#### Section 8 - Paraplegia

This is defined as suffering Total and irreversible loss of the use of any two limbs, but excluding paraplegia caused by accidental, violent, external and visible means.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please state the extent of the paraplegia (please tick) | | | | | | | | | | |
| Irreversible |  | Permanent |  | | Complete |  | Temporary |  | Partial |  |
| State the limbs involved | | | |  | | | | | | |
| Please state the cause | | | |  | | | | | | |

#### Section 9 - Stroke

This is defined as Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent motor deficit, and confirmed with appropriate clinical findings by a specialist neurologist.

For the above definition, the following are not covered:

* Transient ischaemic attack.
* Vascular disease affecting the eye or optic nerve.
* Migraine and vestibular disorders.
* Traumatic injury to brain tissue or blood vessels

|  |  |
| --- | --- |
| Please state the specific type of incident |  |
| Has this lasted for more than 24 successive hours? |  |
| What was the cause? |  |
| State the neurological sequelae present and how long did they last |  |
| Is there any permanent neurological deficit? |  |

#### Section 10 – Medical Evidence/Reports

Please include copies of all the relevant reports and indicate below which reports are enclosed.

|  |  |
| --- | --- |
| Histology | Radiology |
| Laboratory Test Results | ECG Tracings |
| Investigation/Procedure | Any other documentation which may be relevant |

**DECLARATION**

I hereby certify that the above statements are true in every respect.

|  |  |
| --- | --- |
| Name: |  |
| Qualifications: |  |
| Signature: |  |
| Date: |  |
| Address: |  |
| Telephone Number |  |
| Practice Number |  |