WORKMEN’S COMPENSATION & COMMON LAW CLAIM FORM

IMPORTANCE NOTICE

REMEMBER: Incomplete answers will lead to delayed processing of your claim.

<table>
<thead>
<tr>
<th>INSURED</th>
<th>CLAIMANT’S DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name_______________________________________________</td>
<td>Claimant’s Name________________________________________</td>
</tr>
<tr>
<td>Tel. No.______________________________________________</td>
<td>(If different from insured)</td>
</tr>
<tr>
<td>Address______________________________________________</td>
<td>Address________________________________________________</td>
</tr>
<tr>
<td>Policy Number________________________________________</td>
<td>Tel________________________Fax________________________</td>
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<tr>
<td></td>
<td>Business/occupation____________________________________</td>
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<td>Position________________________________________________</td>
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<tr>
<td></td>
<td>Age <em><strong><strong><strong><strong><strong><strong>Height____________Weight</strong></strong></strong></strong></strong></strong></em>__</td>
</tr>
<tr>
<td></td>
<td>Current pay____________________per week/month/day__________</td>
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<tr>
<td></td>
<td>Amount being claimed____________________________________</td>
</tr>
<tr>
<td>ACCIDENT DETAILS</td>
<td></td>
</tr>
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<td>------------------</td>
<td></td>
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<tr>
<td>Accident date</td>
<td>Time</td>
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</table>

Please give particulars of accident, stating exactly how it happened

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Were you engaged in your occupation when it happened? 

Were there any witnesses to the accident? If so, please provide the details

Witness
Address

Witness
Address

What injuries did you sustain? Eye, leg, arm, left or right?

Who is the doctor attending to you?

Office Location?
Is this your usual doctor? __________________________________________________

How long have you been totally unable to attend to any portion of your profession or occupation?
From _________________________To________________________

How long have you been able to partially attend to your profession or occupation?
From _________________________To________________________

Are you entitled to benefits under any other insurance policy, society or club? ____________
If so Give name of company/society and amount______________________________

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MEDICAL CERTIFICATE

Notes for the Doctor

Any fee for this certificate is payable by the insured_______

Total temporary disablement occurs when the patient is wholly unable to attend to all duties related to their profession or occupation.
Partial temporary disablement begins when the patient is able to attend to any portion but not all of the occupation.

1. Name of patient____________________________________________________
2. Are you the usual medical attendant? _________________________________
3. How long have you know him/her? _________________________________
4. Please give details of injuries_______________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
5. When did you first attend to the patient for this current incident? ______________
6. Do the injuries seem consistent with the accident as described herein_______
7. How long has the patient been totally disabled? ________________________
8. How long has the patient been partially disabled? ______________________
9. Has the patient any disease, disability or physical defect currently, apart from this accident?
________________________________________________________________________

10. In your opinion, what is the percentage of disability based on the continental scale?
______________________________________________________________________
I DECLARE that these particulars are true and correct and undertake to forward immediately (and answered) any correspondence to this accident.

Date________________________ Name ________________________________

Signature of Insured ________________________________
(and stamp)

IMPORTANT

1. The doctor attending you must complete the medical certificate

2. Please provide us with the
   • Original medical receipts.
   • Copy of the pay Slip for the month preceding the accident.
   • Copies of the pay slips for the 12 months preceding the accident, if there are other benefits of a permanent nature besides the basic salary.