

ACCIDENT CLAIM FORM STATEMENT BY DOCTOR

A. DETAILS

Scheme name: _____

EMPLOYEE DETAILS

Name: _____

Identity Number: _____ Date of Birth: _____

ACCIDENT DETAILS

Date of Incident/Accident: _____

Description of the incident/accident. _____

When were you first consulted for the incident?

Can the injuries/disability be ascribed to having been caused directly through the abovementioned accident?

Did this injury result in total and permanent loss of:

1. A limb or organ through severance? _____

2. The use of a limb or organ? _____

3. The ability to follow any occupation? _____

If any of the answers to questions is in the affirmative, please motivate: _____%

To your knowledge, can the present disability or loss of limb or organ in any way be traced to any previous injury or illness?

If so, please describe fully:

What is the current status of the patient's condition?

(PLEASE ATTACH COPIES OF RESULTS FOR ALL SPECIAL INVESTIGATIONS PERFORMED)

DOCTOR'S DECLARATION

I certify that the above information is, to the best of my knowledge and belief, true and accurate, and that no information has been withheld, nor has any information regarding the circumstances been omitted.

Doctor's Full Name:

Registration Number: _____ Telephone: _____

Signature _____ Date: _____

Company's Stamp

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