Merx Protect Claim Form

Important: *All claims must be notified as soon as possible, but within 180 days from the date of the injury. Failure to do so may result in the claim being declined for late notification.*

SECTION 1: GENERAL

Policy Number: ______________________________

Name of Insured: ______________________________

Name of Claimant: ______________________________

ID Number: ______________________________

Contact Telephone Number: ______________________________

Contact E-mail Address: ______________________________

Date, time and place of accident: ______________________________

Did the injury occur during working hours/activities?: ☐ Yes ☐ No

SAPS & OAR case number (if applicable): ______________________________

Give a detailed description of how the accident occurred: ______________________________

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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 completed Claim Form. These documents can be forwarded at a later stage to avoid any unnecessary delays.*

1. Copy of the claimant's latest payslip
2. Copy of the claimant's ID document
3. Copy of the driver's employment contract
4. Additional supporting documents per claim type, as noted per section below

SECTION 2: DEATH CLAIM (if applicable)

Date and Place of Death: ______________________________

State the exact cause of death and any important factors connected therewith: ______________________________

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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 completed claim form. These documents can be forwarded at a later stage to avoid any unnecessary delays.*

1. Death Certificate
2. Post Mortem Report

Underwritten by:

Old Mutual Insure Limited is a licensed FSP and Non-Life Insurer.

3. Employers Report of the Incident (if injury on duty)
4. Officer's Accident Report (Traffic Collision 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
7. In the event of the Bereavement Benefit Claim (if applicable), only the death certificate in addition to the Claim Form will be required

SECTION 3: PERMANENT DISABILITY CLAIM

Give full details of the injuries sustained by the claimant: ______________________________

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Name of the attending doctor: ______________________________

Practice Number: ______________________________

Telephone Number: ______________________________

Address: ______________________________

Has any permanent disablement resulted from this accident? ☐ Yes ☐ No

If yes, please give details: ______________________________

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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 completed Claim Form. These documents can be forwarded at a later stage to avoid any unnecessary delays.*

1. Employer's Report of the Incident (if injury on duty)
2. Officer's Accident Report (Traffic Collision Report) if the injury was due to a motor vehicle accident
3. Police Reference Number if injury is the subject of a criminal investigation
4. Copies of any newspaper clipping or eye witness statements that may be available
5. Copies of on-going medical reports detailing the Injury, diagnosis and recovery prognosis

SECTION 4: TTD / INCOME REPLACEMENT BENEFIT (if applicable)

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 completed Claim Form. These documents can be forwarded at a later stage to avoid any unnecessary delays.*

1. Employer's Report of the Incident (if injury on duty)
2. Officer's Accident Report (Traffic Collision Report) if the Injury was due to a motor vehicle accident
3. Police Reference number if injury is the subject of a criminal investigation
4. Copies of any newspaper clipping or eye witness statements that may be available
5. Copies of medical reports detailing the injury, diagnosis and recovery prognosis
6. In the event of serious illness, a copy of the medical report detailing the first diagnosis

SECTION 5: NON-MEDICAL EXPENSE COVER AS A RESULT OF HOSPITALISATION BENEFIT (if applicable)

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

SECTION 6: EMERGENCY EXPENSES SHORTFALL BENEFIT (if applicable)

Original medical accounts and copies of the relevant medical scheme statements associated with the treatment of injuries sustained as a result of the accident, are required when claiming under this section. Please remember that only medical costs not paid by a registered medical scheme will be considered under this section, which includes medical accounts paid directly from a member's medical scheme savings account. Any costs recoverable from COID and/or RAF will not be paid under this section, but should be referred to an accident expert for assistance in recovering these costs.

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. I agree to co-operate where additional reports are called for by the Insurer, which may require me to attend further medical assessments with Insurer appointed Medical Professionals. I understand that any costs associated with this Insurer request will be for the Insurer's cost.

In proceeding with this claim, I wish to confirm that all future correspondence relating to this claim is to be requested from :

Myself, being the Claimant, directly ☐ Both my company and myself ☐

I understand that the Intermediary will be copied in on all correspondence.

Date: ______________________________ Place: ______________________________

Signature of the Claimant or his/her legal representative: ______________________________

I/We acknowledge that the information submitted in this proposal form may be protected by data protection legislation, such as the Protection of Personal Information Act 2013 (POPI) and accordingly hereby consent to the use of such information by Merx Underwriting Managers to:

a) Verify the information disclosed herein against any other source;
b) Communicate with you directly should you request us to and in accordance with relevant regulatory requirements;
c) Compile non-personal statistical information to assist in assessing similar risks;
d) Assess the risk to be underwritten and, if a Policy of Insurance is issued pursuant to and based upon such information, that said information may be used at a later stage to assess any future claims that I/We may have against any such Insurances issued by Merx Underwriting Managers;
e) Transmit your personal information to any affiliate, subsidiary or re-Insurer so that we can provide insurance services to you and to enable us to further our legitimate interests including statistical analysis, reinsurance and credit control;
f) Transmit your personal information to any third party service provider who has a need to know such information in order to perform functions relating to your Policy;
g) Share your personal information on the SAIA policyholder database for the combating of insurance fraud and improved evaluation of risks.

I/We further acknowledge that this consent clause will remain in force even if your Policy is cancelled or lapses.

Due to Merx Underwriting Manager's FSCA Licensing status and in light of the requirements set out in the Protection of Personal Information Act 2013 (POPI) we are not strictly speaking allowed to contact you directly and would generally communicate with you via your broker. However there may be instances where we may need to contact you directly in order to advise you of important matters relating to your Policy. Therefore please indicate below how you prefer to be contacted in the unlikely that we should need to contact you directly.

☐ SMS ☐ Email ☐ Phone ☐ Mobile ☐ Post

DECLARATION BY INSURED

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: ______________________________

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Does the present disability relate in any way to previous injuries or pre-existing conditions or illness: ☐ Yes ☐ No

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?: ☐ Yes ☐ No

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: ☐ Yes ☐ No

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: ______________________________

DECLARATION

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

Name: ______________________________

Qualifications: ______________________________

Practice Number: ______________________________ Telephone Number: ______________________________

Address: ______________________________

Signature: ______________________________ Date: ______________________________