DELPHISURE
GROUP INSURANCE BROKERS CAPE (PTY) LTD
INTERNATIONAL INSURANCE BROKERS AND LLOYDS CORRESPONDENT

SAFA INJURY CLAIM FORM

ATTENTION : **Roz Mouton** (Contact nr - 021 914 1700)
soccer@delphisure.com / insure06@delphisure.com

NAME OF CLUB : _____

NAME OF PLAYER : _____

POSITION PLAYED : _____

DATE OF INJURY : _____

NATURE OF INJURY : _____

HOW WAS THE INJURY SUSTAINED : _____

NAME OF MEDICAL AID : _____

NO CLAIM shall be considered where the claim form and this notification are not received in writing by Delphisure within 30 days of the injury or event occurring.

All information must be completed / supplied in the time frames as requested.

The attached claim form is issued strictly without prejudice or admission of liability

Date issued: _____ **Signature:** _____

The following Medical Certificate must be completed at the expense of the claimant by a duly qualified and registered medical practitioner

MEDICAL ATTENDANT'S CERTIFICATE

Name of Patient in full : _____

Did this patient ever in the past, visit you, professionally relating to **this injury**?
If so, please supply dates and injuries under your attention:

_____

_____

Were the symptoms from which he/she has been suffering due to the accident alone or were they traceable to or aggravated by any other causes?

_____

_____

Provide the dates during which the patient has been totally incapacitated.

NOTE: Temporary total incapacitation occurs when, through accident, the insured is immediately and continuously rendered completely unable to pursue his ordinary occupation or to attend to any business affairs whatsoever.

The **medical attendant** is particularly requested to complete (a), (b) and (c) separately

a) Confined to bed From _____ To _____ inclusive
b) Confined to the house From _____ To _____ inclusive
c) Not confined to the house From _____ To _____ inclusive

NOTE: Temporary partial incapacitation arises when the injury does not solely prevent the insured from pursuing his ordinary occupation or attending to his usual business affairs.

If the patient has been able to attend to a portion only of his usual business or occupation, please provide the dates which he has been partially incapacitated:

From _____ To _____inclusive

From what date did you sanction a return to full work? _____

I hereby certify that I have, **by personal examination**, satisfied myself that the insured is suffering from the injury as described above.

Date: _____ Name of Medical Practitioner: _____

Qualification: _____ Email _____ Contact no. _____

Signature of Practitioner: _____

WITNESS / REFEREE STATEMENT

I hereby declare that the claim documentation, supporting paperwork and particulars are true and correct and to the best of my knowledge and belief.

Dated:

This _____ day of _____ 20 _____

Signature: _____

Certificate to be completed and signed by the Eye Witness and if possible, by the person under whose direction the workman was working at the time of the accident.

I hereby declare that I was present when the incident occurred to _____

On the _____ day of _____ 20 _____

in the manner above stated and that it was caused by that * *was / was not* his willful act, and that he * *was / was not* under the influence of intoxicating liquor or drugs at the time.

Name (PRINT) : _____

Involvement in incident : _____

Contact no. : _____

Occupation : _____

*** Strike out which is not applicable**

ACCIDENT DEPARTMENT CLAIM FORM

Particulars for adjusting the **CLAIM FOR COMPENSATION** in respect of the Accident which occurred to:

(name of injured) _____ on (date) _____ 20 ____

Name of Claimant in full : _____

Present Business or occupation : _____

State the nature of the accident in respect of which is being claim for:

_____

Have you been totally unable to attend to any portion of your business? _____

Provide the date of such total capacity:

a) Confined to bed From _____ To _____ inclusive
b) Confined to the house From _____ To _____ inclusive
c) Not Confined to the house From _____ To _____ inclusive

Provide the dates during which you were able to pursue only portion of your usual occupation :

From _____ To _____ inclusive

The date when you were able to attend to your usual business or occupation?

On the _____ day of _____ 20 _____

Have you ever suffered from an accident of a similar nature to the one under consideration?

_____

Are you now insured against accident in any other office? If so, provide the name of the office and / or have you submitted a claim against RAF Workman's Compensation Medical Aid or any other institution? If so, provide the name of the company:

_____

I hereby declare that the foregoing particulars are true in every respect and that I have not abstained from my ordinary occupation longer than it has been absolutely necessary in consequence of the accident which occurred

On the _____ day of _____ 20 _____

Signature: _____

A MEDICAL CERTIFICATE MUST BE SUPPLIED IN SUPPORT OF EVERY CLAIM