RBS™

INJURY/ILLNESS CLAIM FORM

INSURER ______________ POLICY NUMBER ______________ VAT REG NUMBER ______________

Insured	Name and occupation	
	Address and phone number	
Insured Person	Name and age	
	Business or occupation	
	Address and phone number	
Relationship to the Insured	If employee, give annual earnings defined in the policy	R
	If other, specify relationship	
Injury/Illness	When and where did accident occur or illness commence?	Date / Time / Place
	Give full particulars of the accident and nature of injuries or the name of the illness	
Witness	Name and address	
Doctor	Name and address of doctor who attended to you	
	Name and address of your usual doctor	
Disablement	Period of temporary total disablement	From: To:
	Period of temporary partial disablement	From: To:
	Give date normal occupation resumed	Date:
	Has any permanent disablement resulted? Give details	
Other insurances	Give name of any other insurer with whom insured person is insured	
Previous claims	Give details of all claims made against insurers or in terms of the WCA by the insured person. Compensation for Occupational Injuries and Diseases Act No.150 of 1993	
Declaration/ Authorisation	I/We declare that the above particulars are true in every respect.	

Insured's Signature ______________ Capacity ______________ Date ______________