Bryte

Claim Form
Injury/Illness

Bryte Insurance Company Limited

A Fairfax Company

Please complete this form in BLOCK CAPITALS and send it to your broker or to Bryte Insurance Company Limited.

The information that is sought herein is not intended to be an exhaustive list and Bryte accordingly reserves the right to request any further information deemed appropriate while investigating the claim.

Broker/Agent		Policy number	
Insured	Name and occupation		
	Address and (day) telephone number		
Insured person	Name and age		
	Business or occupation		
Relationship of injured person to insured	If employee, give annual earnings defined in the policy		
	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 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		

Insurers share information with each other regarding domestic policies and claims with a view to prevent fraudulent claims and obtain material information regarding the assessment of risks proposed for insurance. Please refer to the Consent Clause on the policy schedule for more details in this regard.

Payment method

You may select, for added security, for payment of any amount due to you to be made directly into a bank account. Please specify the name of the bank, branch, name of account and account number.

Name of bank ______________________ Branch ______________________

Name of account ______________________ Account number ______________________

Declaration/authorisation

I/We declare that the above particulars are true in every respect.

IMPORTANT

I hereby authorise any hospital, physician, or other person who has attended or examined me, to furnish to the Company, or its authorised representative, all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

Insured person's signature ______________________

Medical certificate

Must be completed by the doctor consulted

The patient must obtain, at his/her own expense, the following certificate from a duly qualified and registered medical practitioner. When the patient is fully recovered a doctor's certificate to that effect should be forwarded to the Insurers showing the periods of partial and total incapacity.

Name of patient ______________________ Height __________ Mass __________

1. When did you first treat the patient in consequence of the accident/illness sustained? ______________________

2. Are you still in attendance? ☐ Yes ☐ No

3. Are you the usual medical attendant of the patient? ☐ Yes ☐ No

   If yes, how long have you known him/her? ______________________

   ____

4. What was the cause of the accident/illness so far as known?

5. What injuries were sustained?

   (a) Region injured (if a hand or an arm, a foot or a leg, state whether it is the right or the left) ______________________

   (b) Are the symptoms from which he/she suffers due to:

      (i) the accident/illness alone, or ______________________

      (ii) are they traceable to any other cause? ______________________

6. Have you any reason to suspect that the patient was not perfectly sober at the time of the accident? ☐ Yes ☐ No

7. Is the patient now, or was he/she at the time of the accident/illness subject to or suffering from any illness or disease irrespective of the accident/illness for which the benefit is claimed? ☐ Yes ☐ No

   If yes, state the nature of same, and to what extent the recovery of the patient may be affected thereby ______________________

   ____

8. If you are the usual medical attendant of the patient, are you aware of anything in his/her previous medical history which might have contributed directly or indirectly to the occurrence of the accident/illness, or which may be likely to retard in any way recovery from it? ☐ Yes ☐ No

   If yes, state the nature of same ______________________

   ____

9. (a) Is the patient confined to bed, bedroom or house by your directions? ☐ Yes ☐ No

   (b) Has the patient at any time been so confined since the date of the accident/illness? ☐ Yes ☐ No

   If yes, give the dates ______________________

   ____

10. If still so confined, please state: (a) Your opinion as to the probable duration of such confinement; (b) Probable date of being able to resume some portion of usual business or occupation.

    (a) ______________________ (b) ______________________

11. Are you prepared to certify that the patient is TOTALLY disabled from attending to any portion of his/her business or occupation? ☐ Yes ☐ No

    (TEMPORARY TOTAL DISABLEMENT occurs when through accidental bodily injury or illness, the patient is immediately and continuously incapacitated for a specific period from attending to business or occupation of any kind).

    If patient has been able to attend to a PORTION only of his/her usual business or occupation, and if this still continues, please state since when, and also the probable date of recovery ______________________

    ____

    (TEMPORARY PARTIAL DISABLEMENT arises when the injury or illness does not wholly prevent the patient from attending to business, or when temporary total disablement ceases, and he/she can attend to some portion of his/her usual business or occupation, but not the whole).

12. If patient has recovered, please state date of recovery ______________________

GENERAL REMARKS ____

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I certify that the aforegoing statements are correct.

Name ____

Qualifications ____

Address ____

Signature ______________________________ Date ______________________________

Protection of Personal Information Act (POPIA)

All personal information collected on this form will be processed in accordance with our privacy statement.

https://www.brytesa.com/pdf/Bryte_privacy_statement.pdf

Signed at ____on the ________ day of ___________________________________ 20 ________

Signature of policyholder ____

Registration number: 1965/006764/06 VAT number: 4530103581
Licensed insurer and an authorised FSP (17703)
Rosebank Towers, 5th Floor, 15 Biermann Avenue, Rosebank, 2196