

**INSURED**

Insured name		Policy number	
Contact number		Email address	

**INCIDENT DETAILS**

Date of loss		Time of loss	
Place where incident occurred		When discovered	
Describe fully how the incident occurred			
Incident caused by another party			

**DEATH CLAIM**

Is there a death claim	
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**DISABILITY CLAIM**

Is there a disability claim	
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**EMPLOYMENT DETAILS**

Name of employer		Contact number	
Address		Employed full time at time of incident	
State the nature of the employee's occupation and daily duties			
Weekly earnings		Monthly earnings	
Medical expenses/compensation payable in terms of WCA or other insurer			

\*The following documents must be submitted:  
 - Copy of employee's Payslip  
 - Copy of employee's Job Description  
 - Copy of Workmen's Compensation submission, if applicable  
 - Copy of any claim submitted to other insurer's, if applicable

**DECLARATION**

I/we hereby provide Alpha Insure (Pty) Ltd or the insurer with the necessary permission and consent to obtain and extract, by any means necessary, any and all information pertaining to the motor vehicle in question in order to validate the damages/theft and claim in this regard.

I/we hereby acknowledge that Alpha Insure (Pty) Ltd or the insurer may make an enquiry, where applicable, to any relevant authority or institution, (including, but not limited to) the South Africa Revenue Services (SARS), South African Police Services (SAPS), South African Insurance Crime Bureau (SAICB), any registered financial, insurance or banking institutions, or any of their authorised representatives, to obtain, confirm or validate any information, related information or details as being reported on or related to any information contained in this claim form.

I/we hereby waive my/our right to privacy with regard to underwriting or claims information (including credit information) that I/we provide or that is provided by another person on my/our behalf in respect of any insurance policy or claim made or lodged by me/us. I further consent to such information being disclosed by me, or any person I represent in terms of this insurance policy, to any other insurance company or its agent.

We hereby declare the afore going particulars to be true in every respect.

_____	_____	_____	_____
Full Name	Capacity	Date	Signature

Insured

Full Name

Capacity

Date

Signature

It is important that you notify the insurers immediately should you become aware of any impending prosecution, inquest or demand. Any personal injuries noted must be reported separately to the applicable accidents fund (i.e. Road Accident Fund) without delay.