CHUBB®

Contact us for more information:

T 0860 223 252
F 011 783 0812
myclaim@chubb.com

Claim form

Critical Illness

Please write in black ink and use block capital letters.

- Please return the completed claim form together with any enclosures to your insurance broker or to Chubb at the address shown
- The completion and/or submission of this claim form to us does not constitute an admission of your claim by Chubb Insurance Limited South Africa

Please ensure:

☐ That the doctors statement is completed and is accompanied by the claim form upon submission

Insured details – to be completed by the policy holder

Policy Number:

Full Name of Insured:

Physical Address:

Full Name of Insured Person:

Business Telephone Number and Contact Person:

Insurance Broker:

Email:

Contact Person:

Email:

Claimant/employees details (please note this must be completed by the employer)

a) Full name of employee:

b) Date of Birth of the employee:

c) Identity number of the employee:

d) Employees occupation:

e) Date of employment:

f) What are the employees annual earnings?

g) Has the employee been booked off work for the illness being claimed for? ☐ Yes ☐ No

If Yes, from what date?

Claimant/employee (please note this section must be completed by the employee/claimant)

What is the nature of your illness or disease?

When did you become aware of your illness of disease?

On what date was the diagnosis provided by the Doctor?

Is this a recurring illness or disease?

What is the Name and Address of the Doctor you first consulted for your illness/disease?

Authorisation

Please note that this claim form will not be accepted if this declaration has not been signed by the employee/claimant.

I _____ hereby declare and warrant that the information provided in this claim form is in every respect complete, correct and true and that the signing of this claim form constitutes written authority for Chubb Insurance Limited to inspect or investigate any records or details relevant to this claim. I/We further declare that any misrepresentation and or non-disclosure in respect of the information provided shall render the claim null and void.

I authorise any medical practitioner, hospital or other person to provide Chubb Insurance Limited with any information they require relating to the medical to which the claim relates. I agree that this consent shall remain in force at all times, and that a photo-copy or fax for this declaration shall be accepted as original. I agree and accept that Chubb Insurance Limited may request additional information from any medical practitioner, hospital or any other person not specifically requested herein, on completion and submission of this form and any other documentation as submitted by me.

Signed by the employee/claimant on this _____ day of _____ 20 _____

Signed by the Insured Company/Employer on this _____ day of _____ 20 _____

In the Capacity as the Insured Company's _____

Doctor's statement

This section must be fully completed by the patient's usual medical attendant – any fee for completion of this section is the responsibility of the insured person.

Title

Miss

Patients Full Name and Surname:

Date of Birth:

Height:

Weight:

Full details of illness/ disease:

Final diagnosis:

1) On what date did the first symptoms appear?

2) On what date did the patient become aware of the illness /disease?

3) When did the patient first recieve medical attention for the illness/disease?

4) Has the patient ever suffered with this or any similar condition before the present episode? ☐ Yes ☐ No

5) If Yes, please give details including dates of treatments and consultations:

6) Kindly provide any other information that you may feel is relevant to assist us in assessing the claim:

7) Are you the patient's usual Doctor? ☐ Yes ☐ No

8) Is the patient still incapacitated? ☐ Yes ☐ No

9) If Yes, when will the patient be able to return to work?

10) If No, when did incapacity cease?

Signature

Full Name of Doctor:

Practice Number:

Dr Signature:

Date:

Full Address:

Contact Number:

Chubb. Insured.℠