



ACCIDENT / INJURY DETAILS & UNDERTAKING

Application for payment or refund of medical, dental, hospital and other charges in respect of injuries, illness or a condition caused by an accident or incident (other than an accident at work), or violent means, for which another party may be liable for damages, must be submitted on this form.

A. TO BE COMPLETED IN ALL CASES

1. Full name of the member:..... Medical Aid
- Occupation:.....
2. Residential Address:
3. Telephone Number of member: HomeWork:Cell
4. Name and Address of the employer
5. Full name and residential address of person injured (if not member)
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6. Relationship to Member
7. Telephone Numbers of person injured :HomeWork.....Cell.....
8. Particulars of accident or injury occurred:
(a) Date accident or injury occurred:.....Time..... Place
- (b) Injury due to : (Please mark appropriate box)

Motor accident

Assault

Other accident

- (c) Statement by member.(This statement must set out, as fully possible, the circumstances of the accident or injury

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B. TO BE COMPLETED IN ALL CASES OF MOTOR ACCIDENT, ASSAULTS AND FIREARM ACCIDENT

1. Has the accident or incident been reported to the Police?
2. If so, at which Charge Office?.....Case No
3. If not reported to the Police, why not?.....

4. Name, Address , telephone numbers and occupation of other people involved in the accident or incident
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5. Has the member instituted /does he propose to institute a claim against a third party for recovery for recovery of damages?
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6. If so, against whom?.....
7. If not, why not ?.....(See Footnote1)

Whenever the Public Prosecutor intends taking action against the other party involved, the Medical Scheme requires the member to institute legal action against the other party in question for recovery of Medical / Dental expenses. Once the Medical Scheme is satisfied that such an action has been instituted by the member and the name and address of the attorney, acting on behalf of the member, has been furnished as well as an UNDERTAKING signed by the member (to the effect that monies disbursed by the Medical Scheme as a result of the injury will be refunded to the Medical Scheme), the Medical Scheme will proceed to pay the relevant accounts on behalf of the member in terms of the applicable Rules.

8. Were there any witnesses to the accident or incident?
9. If so, furnish the names, addresses and telephone numbers if known :
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C. UNDERTAKING (To be completed by the member in respect of all claims for which any other party may be liable).

I, the undersigned:Membership No.....

Employed by hereby undertake to refund

to the Medical Scheme any and all sums of money disbursed to me or on my behalf in respect of expenses incurred for treatment of injuries, illness or conditions resulting from any accident or incident which took place

on.....day of..... 200....

Subject to any apportionment which may be applied.

I undertake to make such refund to the Scheme within seven (7) days of receiving such payment from the other party.

In the event that I, with such diligence as shall satisfy the Committee of the Medical Scheme,

prosecute and pursue any and all rights to compensation from any person or persons against whom I may, in law, be entitled to recover damages and costs sustained as a result of such accident or incident and shall fail to recover any such compensation, at the discretion of the Committee, the Medical Scheme may agree to release me from this undertaking. In this regard, I undertake to provide the Scheme with documentary proof of the institution of a claim and proof of the failure or repudiation of such claim, within one (1) month of same occurring.

Signed at:.....on the.....day of 200.....

Witnesses to: 1.

 2.

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Signature of member

MOTOR VEHICLE ACCIDENT (MVA) REIMBURSEMENT UNDERTAKING

TO BE COMPLETED BY MEMBER:

To: (name & address of attorney)

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I the undersigned, do hereby irrevocably authorise the above to deduct all monies due by me to The Medical Scheme in respect of medical claims paid by the Scheme in connection with the M.V.A. on.....from any award made to me by the Road Accident Fund and/or any Third Party and to pay over these amounts to the Medical Scheme on my behalf.

SIGNED.....

DATE:.....

NAME.....

CONTRACT NO.....

TO BE COMPLETED BY ATTORNEYS:

We hereby confirm our undertaking that upon the successful finalisation of the above claim, we will reimburse the Medical Scheme directly for all the medical expenses we can recover from the Road Accident Fund and/or any other Third Party.

SIGNED..... **DATE**.....

For and on behalf of.....(Name of Attorneys)

Address and telephone number of Attorney:

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