SPECTRUM
Since 1976

INJURY / ILLNESS CLAIM

Insurance Company

Policy number

INSURED

Name | ID No | Phone No

Address

INJURED PERSON

Date | Time | Place

Description of Accident

Is injured person and employee of insured or a relative? No | If employee, give earnings, if relative, give details

Witness name | Address | Tel

Doctor's name | Address | Tel

Normal GP | Address | Tel

DISABLEMENT

Period of temporary total disablement From To

Period of temporary partial disablement From To

Date normal occupation resumed

Details of any previous claims | Date | Insurer

Is this covered by any other insurer ? No | Insurer

DECLARATION AND AUTHORISATION

I / we declare that the above particulars are true in every respect and authorise any hospital, physician or other person who has attended or examined me, to furnish any information with respect to any illnessor injury, medical history, consultation, prescriptions, treatment or copies of hospital and medical records.

Insured signature

Injured Person signature

Date

PRINT FORM FOR SIGNATURE