FORM 1

CLAIM FOR COMPENSATION AND MEDICAL REPORT

(Sections 17(1) and 24(1)(a) of Act No. 56 of 1996 and regulation 3(1) of the Regulations under the Act.)

Notes:

(i) A separate form must be completed and lodged with regard to each injured or deceased person in respect of whose bodily injury or death compensation is claimed.
(ii) In order for the Fund to be able to deal with this claim expeditiously it is essential that all the required supporting vouchers and statements should accompany this form and in the case of item 8 of this form it is desirable also to-
   (a) attach all medico-legal reports in the possession of the claimant; and
   (b) indicate, with regard to a claim for future loss of earnings, on a separate statement how such loss is calculated.
(iii) Written authority for inspection by or on behalf of the Fund of all records regarding the injured or deceased person which may be in the possession of any hospital or medical practitioner must accompany this form.
(iv) Items 1 to 5 of this form must be completed before this form is submitted to the medical practitioner for completion of the medical report.
(v) Where blocks are provided for the purpose of replying to a question, place a cross in the appropriate block.

1. CLAIMANT:

   (a) (i) Full name and residential address of claimant.................................................................
   (ii) Citizenship................................................(iii) Identity/Passport No......................................
   (iv) Telephone No: Home ................................ Work ................................................
   (b) If the claimant is claiming in a representative capacity on behalf of another person, state-

   (i) Capacity in which claimant is acting ....................................................................................
   (ii) Full name and address of person on whose behalf compensation is being claimed
        .................................................................................................................................
   (iii) Identity/Passport number of such person...........................................................................
   (iv) Relationship of claimant to such person..........................................................

(Photocopies of relevant identity documents/passports and marriage and birth certificates, as the case may be, should accompany this form.)

2. PARTICULARS OF MOTOR VEHICLE FROM THE DRIVING OF WHICH THIS CLAIM ARISES:

   (a) Registration letters and numbers........ (i) Make............................................................... 
   (ii) Type of body...........................................................................................................
   (b) Name and address of owner at time of accident.................................................................
   (c) Name and address of driver at time of accident.................................................................
   (d) If the identity of neither the owner nor the driver has been established, state-

   (i) Any additional information about motor vehicle ............................................................
   (ii) What steps were taken to establish the identity of the owner or the driver of the motor vehicle..........

(Attach a separate statement if necessary.)
3. PARTICULARS OF ACCIDENT:

(a) Date...................................................(b) Time..............................................(c) Place..................................................

(d) Police station at which reported and police reference number..................................................

.................................................................................................................................

(e) Attach an affidavit (supported by a rough sketch of the scene of the accident) in which particulars of the accident are fully set out.

(f) Attach copies of all available statements (including eyewitness accounts) and documents (including police accident report and plan).

4. PARTICULARS OF ANY OTHER MOTOR VEHICLES INVOLVED IN ACCIDENT:

(a) Registration letters and numbers ................................................................. .................................

(b) (i) Name of owner at time of accident............................................................... ................................

(ii) Address...................................................................................................................

(iii) Occupation...........................................................................................................

(c) (i) Name of driver at time of accident............................................................... ................................

(ii) Address...................................................................................................................

(If more than two other motor vehicles were involved the particulars should be set out on a separate statement attached to this form.)

5. PARTICULARS OF INJURED OR DECEASED PERSON:

(a) Full name and address..................................................................................................................

(b) Identity/Passport No. ..................................................................................................................

(c) Sex............................................. (d) Date of birth.............................................

(e) Marital status at time of accident: never married married divorced widowed

(f) If married: in community of property out of community of property customary union

(g) Business or occupation..................................................................................................................

(h) At the time of the accident, was the person travelling in one of the motor vehicles described in either item 2 or item 4? YES NO

(i) If YES, state:

(i) Registration letters and numbers of motor vehicle..............................................................;

(ii) whether as a passenger or driver..........

(j) If the person was not travelling as a passenger or driver in one of the motor vehicles described in either item 2 or item 4, (i) what was his/her mode of conveyance?........................................ ..... or (ii) was he/she a pedestrian? YES NO

(k) Name and address of usual medical practitioner.................................................................

(l) Name and address of all medical practitioners who attended him/her after the accident
.................................................................................................................................

(m) (i) At which hospital or nursing home or other place did he/she receive treatment after the accident?
.................................................................................................................................

(ii) For what period as in-patient (from .............................................. to ..............................................) and/or out patient (from .............................................. to ..............................................) ?

(iii) Classification for hospital purposes: hospital patient private patient

(iv) Hospital reference number .................................................................................................

(n) Was he/she suffering from any physical defect or infirmity immediately prior to the accident?
YES NO

(o) If YES, give details ..................................................................................................................

(p) (i) Name and address of employer at date of accident (if more than one employer, state names and addresses of all) .................................................................................................................................
(i) Period in employment, from......................... to ..........................................................
(ii) Nature of work .......................................................... ..........................................................
(iv) Date of resumption of work ..........................................................
(q) Was he/she injured or killed in the course of his/her employment? YES ☐ NO ☐
(r) State his/her income for the 12 months immediately preceding the accident:

R

(i) from employment.......................................................... ..........................................................

(ii) from any other source (give details)................................. ..........................................................

Total.................................................. R...........................................

6. IF THE PERSON MENTIONED IN ITEM 5 WAS KILLED, THE FOLLOWING ADDITIONAL INFORMATION IS REQUIRED IN RESPECT OF SUCH PERSON:
(a) Place where death occurred..........................................................
(b) Date of death..........................................................
(c) Is it known whether an inquest was held? YES ☐ NO ☐
(d) If known, state in what court.................................................Date..........................

and reference number.......................... (attach a copy of the relevant inquest record if available).
(e) Name and address of the executor of the deceased’s estate..........................................................


6. IF THE PERSON MENTIONED IN ITEM 5 WAS KILLED AND COMPENSATION IS CLAIMED BY OR ON BEHALF OF A DEPENDANT OF THAT PERSON, THE FOLLOWING INFORMATION IS REQUIRED IN RESPECT OF SUCH DEPENDANT. (If compensation is claimed by or on behalf of more than one dependant the information required by this paragraph in respect of each dependant should be set out on a separate statement, which should be attached to this form.)
(a) Full name and address..........................................................
(b) Identity/Passport No..........................................................
(c) Sex ................................................ (d) Date of birth..........................................................
(e) Relationship to deceased person..........................................................

(Attach a photocopy of relevant marriage and/or birth certificates, as the case may be)
(f) Marital status at time of accident: never married ☐ married ☐ divorced ☐ widowed ☐
(g) If married: in community of property ☐ out of community of property ☐ customary union ☐
(h) Business or occupation ..........................................................
(i) Is he/she suffering from any physical defect or infirmity? YES ☐ NO ☐
(j) If YES, give full particulars..........................................................

(k) Name and address of employer at date of accident and how long employed by such employer (if more than one employer, state names and addresses of all)..........................................................

..........................................................................................................................
..........................................................................................................................
(l) State his/her income for the 12 months immediately preceding the accident:

R

(i) from employment..........................................................

(ii) from any other source (give details).................................

Total.................................................. R...........................................

(m) Details and amount of any inheritance or any other benefits received from the estate of the deceased or accruing from any other source as a result of the death of the person referred to in item 5, other than insurance and/or pension moneys..........................................................
..........................................................................................................................
..........................................................................................................................

8. COMPENSATION CLAIMED:

Precise details must be given in respect of the following items and must be supported by vouchers, where applicable. (If necessary, the information required by this item may be set out on a separate statement duly signed and attached to this form.) [See also Note (ii) at top of form.]

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td></td>
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<tr>
<td>(c)</td>
<td></td>
</tr>
</tbody>
</table>
(d) Estimated future medical expenses.......................... ............................................
(e) Loss of earnings/support from date of accident to date hereof ............................................
(f) Estimated future loss of earnings/support.......................... ............................................
(g) Funeral expenses.......................................................... ............................................
(h) General damages (pain and suffering, permanent disability, etc) ............................................

Total.................................................. ............................................

9. IF THE PERSON MENTIONED IN ITEM 5 WAS KILLED OR INJURED IN THE COURSE OF HIS/HER EMPLOYMENT STATE:

(a) Whether the claimant is entitled to compensation under the Compensation for Occupational Injuries and Diseases Act, 1993      YES [ ] NO [ ]
(b) If the claimant has already been compensated in terms of the Compensation for Occupational Injuries and Diseases Act, 1993, state amount received.......................................................... and Compensation Commissioner's reference..........................................................

I hereby declare that to the best of my knowledge and belief the information set out in this form is true and correct in every respect.

Signed at........................................... this ........................................... day of.................................... 19.............

As witnesses:
1. ..........................................................
2. ..........................................................

Signature of claimant (mentioned in item 1) or authorised legal representative.  (In the latter case, proof in writing that he/she is authorised to act as legal representative of the claimant must accompany this form.)

MEDICAL REPORT

Notes:

(i) Section 24(2)(a) provides that this report shall be completed by the medical practitioner who treated the injured or deceased person for the bodily injuries sustained by him/her in the accident from which this claim arises or by the superintendent (or his/her representative) of the hospital in which the injured or deceased person was treated for such bodily injuries.

(ii) Where blocks are provided for the purpose of replying to a question, place a cross in the appropriate block.

1. (a) Name of person to whom this report relates..........................................................
(b) Are you satisfied that this is the person mentioned in item 5 of the claim form? YES [ ] NO [ ]

2. Date when first seen after accident..........................................................

3. Did you treat him/her at any time before the accident? YES [ ] NO [ ]
   If YES, give date of last such treatment and nature of ailment..........................................................

4. Parts of body injured and degree of injuries:

   Minor................. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
   Fairly severe........... [ ] [ ] [ ] [ ] [ ] [ ] [ ]
   Severe................ [ ] [ ] [ ] [ ] [ ] [ ] [ ]

   Head  Chest  Neck  Abdomen  Back  Upper  Lower  Pelvis
   limbs  limbs
5. (a) Give full details of the nature of the injuries and any complications (e.g. fractured ribs with haemothorax, compound fracture left tibia, disfigurement, etc.)

(b) State treatment given to date:

(c) Is hospitalisation foreseen in connection with the future treatment referred to in (a) above? YES NO

(d) If YES, state:

(i) Expected date of such hospitalization

(ii) Expected duration thereof

(iii) Estimated cost thereof

(v) Expected date thereof

6. Is permanent disability expected? YES NO

If YES, give full details

If NO, has his/her condition stabilised?

7. Is specialist treatment being given? YES NO

If YES, give name and address of specialist

8. (a) Is future medical treatment foreseen? YES NO

(b) If YES:

(i) What will the probable nature of such treatment be and in respect of which injuries?

(ii) Expected date thereof

(iii) Expected duration thereof

(iv) Estimated cost thereof

(c) Is hospitalisation foreseen in connection with the future treatment referred to in (a) above? YES NO

(d) If YES, state:

(i) Expected date of such hospitalization

(ii) Expected duration thereof

9. Have the injuries aggravated any pre-existing pathological condition? YES NO

10. Has any such pre-existing pathological condition aggravated the effects of trauma? YES NO

11. If the answer to either item 9 or 10 above is YES, give full details

12. Has the person been confined to a hospital/nursing home? YES NO

If YES, state:

(a) Name and address of hospital/nursing home

(b) Hospital reference number

(c) Date when discharged or when discharge is expected

13. If in employment at date of accident, state date when return to employment is expected

14. In the case of death, state:

(a) Date of death

(b) Cause

(c) Did any pre-existing pathological condition contribute to death? YES NO

(d) If YES, give full details

Name of medical practitioner

Qualifications

Address

Signature Date