AIG
10 Queens Road
Parktown, 2193
PO Box 31983
Braamfontein, 2017

T 0861 488 864
F +27 11 551 8653
directclaims@aig.com
www.aig.com

Voluntary Employee Benefits Claim Form

NOTES:

1. For all claims, please complete Section 1 & 2.
2. Please provide a copy of your latest salary advice and application form.
3. All accidents that could lead to a claim must be notified to us within 30 days of the accident.

TYPE OF CLAIM:

- ☐ Accidental death
- ☐ Permanent disability
- ☐ Hospitalisation
- ☐ Temporary total disability
- ☐ Serious Illness

SECTION 1

POLICYHOLDER'S DETAILS

Company name:	
Policyholder:	
The Insured Person:	
Date of Birth:	
Units of Cover – Individual ☐	Family ☐
Relationship to Policyholder:	
Occupation:	
Postal address:	
Code:	
E-mail address:	
Tel no.:	Fax no.:

BANKING DETAILS

Account number:
Account Holder's name:
Name of bank/building society:
Type of account:
Branch name:
Branch code:

DECLARATION AND AUTHORISATION

By Policyholder or Legal Representative

I declare that the information given is true and complete to the best of my knowledge and belief and authorise any hospital, physician or other person who has attended to me to furnish to AIG Life South Africa Limited or its representatives any and all information with respect to any sickness or injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. I agree that a photostatic copy of this authorisation shall be considered as effective and as valid as the original.

Signature ______________________ Date ______________________

Insurance Fraudline
0860 002526
insurance@fraudline.co.za

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SECTION 2 – DETAILS OF ACCIDENT

Date of accident:	Time:	am/pm:
Place:		
Give full details of how the accident occurred?		
State, as fully as possible, what injuries were suffered:		
Name and Address of usual doctor:		
Tel/Fax of usual Doctor:		

SECTION 3 - ACCIDENTAL DEATH

Full names and surname of the deceased:	
Date of birth:	Date of death:
Please state the exact cause of death:	

PLEASE PROVIDE THE FOLLOWING DOCUMENTS:

An original certified copy of the death certificate.

The Post Mortem report.

The full inquest report, including all witness statements pertaining thereto.

The police accident report, if death was due to motor accident.

The police reference number if death was the subject of a criminal investigation.

Copies of any newspaper clippings or eye witness statements that may be available.

In the event of the deceased having been hospitalised prior to death, please attach a copy of the relevant hospital account or have SECTION 4 completed by hospital.

AIG Life South Africa Limited is a licensed Financial Services Provider FSP No. 15804 Reg. No. 2001/016602/06

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SECTION 4 – HOSPITALISATION

THIS IS TO BE FULLY COMPLETED BY THE RELEVANT HOSPITAL AUTHORITY. THE INSURED PERSON MUST HAVE BEEN HOSPITALISED FOR AT LEAST 24 HOURS. PLEASE PROVIDE A COPY OF YOUR HOSPITAL ACCOUNT.

Patient:

Reason for hospitalization:

Hospitalisation period:

Admission date: Time:

Discharge date: Time:

Ambulance transportation: Yes ☐ No ☐ (tick applicable box and attach the original account)

Signed: Date:

Name: Capacity:

Hospital Stamp:

SECTION 5 – PERMANENT DISABILITY

THIS IS TO BE FULLY COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER WHERE A PERMANENT DISABILITY COULD RESULT.

Doctor's name:

Postal address:

Code:

Tel no.: Fax no.:

Patient's name:

Age/Date of birth:

1. When did the accident occur?
2. Please give details:

3. What injuries were sustained?

Under the terms and conditions of this policy, it is necessary to evaluate the level of the permanent disability solely as a result of the accident. 100% ☐ 75% ☐ 50% ☐ 25% ☐

If you feel that a different percentage is more appropriate, please state:

How long have you been treating the patient prior to the accident?

If any operations were performed, please give details:

Has the condition now stabilised?

If no, what is the approximate date of stabilisation?

DECLARATION

I certify that my answers to questions in SECTION 4 and SECTION 5 are true and complete to the best of my knowledge and belief.

Signature____Date ____

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This form to be fully completed by policyholder or legal representative

SECTION 6 – TEMPORARY TOTAL DISABILITY
PLEASE PROVIDE US WITH A DOCTOR'S LETTER STATING WHAT KIND OF INJURIES WERE SUSTAINED AND THE DATES BOOKED OFF WORK.
Name of treating doctor:
Injuries sustained:
First date of sick leave:
Date of return to work:

SECTION 7 – SERIOUS ILLNESS BENEFIT
PLEASE PROVIDE US WITH A DOCTORS LETTER TO CONFIRM ILLNESS.
Diagnosis:
Date of Diagnosis:
Name of Treating doctor: