Claim Form
Motor Personal Accident

Bryte Insurance Company Limited

A Fairfax Company

Registration number: 1965/006764/06 VAT number: 4530103581

Authorised Financial Services Provider No. 17703

15 Marshall Street, Ferreirasdorp, Johannesburg, 2001 PO Box 61489, Marshalltown 2107

Please complete this form in BLOCK CAPITALS and send it to your broker or to Bryte Insurance Company Limited.

The information that is sought herein is not intended to be an exhaustive list and Bryte accordingly reserves the right to request any further information deemed appropriate while investigating the claim.

With respect to item 7 below, if the space does not allow you to list all injured or deceased persons, please attach a separate form for those details. Where blocks are provided for the purpose of replying to a question, please place a (X) in the appropriate block.

1. Broker details	
(a) Name	
(b) Agency number	
2. Policy details	
Number	
3. Insured	
(a) Full name and residential address of policyholder	
(b) Contact details	
(i) Work	(ii) Home
(iii) Cell	
4. Particulars of motor vehicle in which injured person(s) was travelling	
(a) Make and model	
(b) Registration number	
(c) Type of body	
(d) Name and address of the driver at the time of the accident	
(e) 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 of the motor vehicle	
5. Particulars of the accident	
(a) Date	
(b) Time	
(c) Place	
(d) Police station at which reported and police reference number	
(e) Name of the driver	
(f) Driver's licence number (please supply us with a copy)	
6. Particulars of any other vehicles involved in accident	
(a) Registration numbers	
(b) Name and address of the third party driver at time of accident	

7. Particulars of injured or deceased person(s)	
(a) Full name(s) and address(es)	
(b) Date of birth(s)	
(c) At the time of the accident, was (were) the person(s) travelling in the passenger compartment of the motor vehicle described in item 4 above?	☐ Yes ☐ No
(d) Name and address of usual medical practitioner	
(e) Name and address of medical practitioner who attended him/her after the accident	
(f) Was he/she suffering from any physical defect or infirmity immediately prior to the accident?	☐ Yes ☐ No
(g) If yes, give details	
(h) Was the injured or deceased person wearing a seat belt at the time of the accident?	☐ Yes ☐ No
8. If the person mentioned in item 7 is deceased, 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	
(attach a copy of the relevant inquest record if available) (Please attach copy of the death certificate as well)	
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
As witnesses:	1.
	2.
Signature of Insured	

Medical Certificate

Must be completed by the doctor consulted.
The patient must obtain, at his/her expense, the following certificate from a duly qualified and registered medical practitioner.

Name of patient	
1. Date when you first treated the patient in consequence of the injury sustained in a motor accident	
2. Are you still in attendance?	☐ Yes ☐ No
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. If you are the usual medical attendant of the patient, are you aware of anything in his/her previous medical history which might have contributed directly or indirectly, to the occurrence of the accident, or which may be likely to retard in any way recovery from it?	
5. Parts of the body injured ☐ Head ☐ Chest ☐ Neck ☐ Abdomen ☐ Back ☐ Upper limbs ☐ Lower limbs ☐ Pelvis	
6. (a) Give full details of the nature of the injuries and any complications (e.g. fractured ribs with haemothorax etc)	
7. Is permanent disability expected?	☐ Yes ☐ No
If yes, give full details	
8. Have you any reason to suspect that the patient was not perfectly sober at the time of the accident?	☐ Yes ☐ No
9. Is the patient now, or was he/she at the time of the accident subject to or suffering from any illness or diseases irrespective of the accident?	☐ Yes ☐ No
If yes, state the nature of the same, and to what extent the recovery of the patient may be affected thereby	
10. Are you prepared to certify that the patient is TOTALLY DISABLED from attending to any portion of his/her business or occupation?	☐ Yes ☐ No
I/We declare the above particulars are true in every respect.	
Name	Qualifications
Signature	Date
Address	
Signature of Insured	Date