



ASSOCIATED INSURANCE BROKERS

Reg No 2004/022911/07

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STATED BENEFITS CLAIM FORM

The issue of this form is not an Admission of any liability.

Claim Number:

EMPLOYER: 1 Name or style of Employer and full address:	
2 State a) Policy Number:	a)
3 Nature of trade or business	
INJURED WORKMAN: 4 Name and full address	
5 a) Occupation b) Sex c) Age d) Marital Status e) Identification no.	a) b) c) d) e)
6. Was he in your direct employ or in that of a Sub-Contractor?	
7. If in your employ, how long has he been employed?	
8. Give rate of pay at time of Accident: a) Per hour b) Per shift c) Per week d) Per month e) Number of hours or shifts Worked per week	a) b) c) d) e)
9. State amount of average weekly / monthly earnings. Note: Average earnings mean the average earnings of the employee for the 12 months immediately preceding the accident, or such shorter period that he has been in your employ	
10. State FULLY the nature of the work he was doing at the time of the accident.	
11. How did the accident occur?	
12 a) Where did the accident occur? b) Magisterial District?	a) b)

13 When did the accident occur?	At _____ a.m. / p.m. on the _____ day of _____ 20____
14 Date when injured person ceased working	
15 Give names and addresses of witnesses of the accident	
16 Was the accident caused by: a) Violation of rules: b) Carelessness of injured Workman c) (I) Any defect of machinery or plant (ii) If so, had such defect been brought to your notice	a) b) c (i) (ii)
17 a) Was the injured person perfectly sober at the time of the accident? b) Under whose direction was he at the time of the accident? c) Was same caused by carrying out such direction?	a) b) c)
18. Was the injured person suffering at the time of the accident? a) From ill-health or bodily defect or infirmity of any description? b) Were you aware of such ill-health, defect or infirmity?	a) b)
19. State generally the nature of the injuries received.	
20. State to what extent the injured person is disabled, and whether absolutely prevented from following his employment.	
21. State what you consider to be the probable duration of total disablement	
22. Has the injured person returned to work?	
23. If so, give date of return	
24. a) Give name and address of injured Workman's Medical Attendant c) If in hospital, give name of same.	a) b)

