

**LSG INSURANCE SERVICES PINNACLE INCOME PROTECTION PLAN  
CLAIM FORM - PERSONAL TRAINERS**



1. The issue of this form does not constitute an admission of liability under the policy.
2. Should this claim be approved the payment will automatically be credited to the account from which your premiums are collected.
3. If payment is to be credited to an alternative account, please provide the relevant details in **Section 1**.
4. Please complete **Section 1** and have **Section 3** completed by the acting doctor, i.e. the doctor whom you have consulted most regularly for your condition.
5. **Section 2** is to be completed by your employer. Should you be self employed please complete business details.
6. **Please attach copies of your VA Fee schedules** for three months prior to incapacitation. If you are self employed please attach copies of three months bank statements reflecting earnings deposited. This requirement may change depending on circumstances.

SECTION 1: PERSONAL DETAILS	
Policy Number:	
Surname:	
Name(s):	
Date of Birth:	
Postal Address:	
Telephone Number:	
Occupation:	
Describe your duties:	
Is this claim due to an accident or illness?	
When did the incident/condition first occur?	
Describe the incident/condition in detail:	
On which date did you first consult a doctor:	
Is this incident/condition a re-occurrence:	
If <b>YES</b> please provide full detail with applicable dates:	
Please provide full medical history relating to this incident/condition:	
Date	Condition / Treatment received
Please complete the following details of the doctor you consulted for this incident/condition:	
Name:	
Address:	
Telephone number:	
Fax number:	
Is this your <b>usual</b> house doctor?	
If <b>NO</b> , please state the following details of your <b>usual</b> house doctor:	
Name:	
Address:	
Telephone number:	
Fax number:	

**SECTION 1 (continued): EMPLOYER DETAILS AND DECLARATION**

Please state name and address of you current employer:

Please state your **Gross Monthly Income** at the time of this claim: **R**

If you are self employed this is to be substantiated by a copies of the last three tax returns together with a statement from your accountant.

**ELECTRONIC FUNDS TRANSFER**

Account Number:	
Account Holder Name:	
Bank Name:	
Type of Account:	
Branch Name:	
Branch Code:	

**DECLARATION AND AUTHORISATION*****By Policyholder or Legal Representative***

I certify that my banking details are correct, failing which, Health & Accident Underwriting Managers (Pty) Ltd is absolved against all direct losses, liabilities, suits, proceedings, costs, demands, charges and expenses (including all legal and professional fees and disbursements) in respect thereof. I accept that it is my responsibility to inform Health & Accident Underwriting Managers (Pty) Ltd of any changes in my banking details, failing which, Health & Accident Underwriting Managers (Pty) Ltd will accept no responsibility for changes which are not communicated or not communicated timeously. I further 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 Health & Accident Underwriting Managers (Pty) Ltd 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 records.

I agree that a photocopy or facsimile of this authorisation shall be considered as effective and as valid as the original.

Signature:		Date:	YEAR/MONTH/DAY
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Please attach any/all medical certificates from the usual medical attendant that is consulting you for this incident/condition. Failure to attach the required information will cause delay in the processing of the claim. Please make sure you attach all relevant documentation to this claim form on submitting.

**SECTION 2: CERTIFICATE OF ABSENCE**

(to be completed by your employer - if employed)

I / We declare that according to our records:	Mr / Mrs / Miss / Dr / Prof	
Name (s):		
Surname:		
Was absent from work from date:	To date:	
Due to:		
Signature:	Date:	YEAR/MONTH/DAY
Name in full:		
Capacity:		
Telephone number:	Fax number:	

COMPANY STAMP

**Administrators:**  
 Health & Accident Underwriting  
 Managers (Pty) Ltd  
 22 Stiglingh Road, Rivonia  
 PO Box 324, Rivonia, 2128  
**Tel: (011) 234 7333**  
**Fax: (011) 234 7351**  
**email@healthacc.co.za**

**Please send all completed claim forms and supporting documents to LSG Insurance Services who will liaise with Claim Administrators:**  
 Tel: 086 111 5140  
 Fax: 086 111 5139  
 Email: [rowena@lsginsurance.co.za](mailto:rowena@lsginsurance.co.za)

**SECTION 3: CERTIFICATE OF USUAL MEDICAL ATTENDANT**

(to be completed by medical attendant)

Name of patient:			
Brief description of patient's injury/illness:			
When did the patient first consult a doctor:			
Is this incident/condition a re-occurrence:			
If <b>YES</b> please provide full details with applicable dates:			
Please provide full medical history relating to this incident/condition:			
Date	Condition / Treatment received		
<b>DOES THIS INCIDENT/CONDITION IN ANY WAY RELATE TO THE FOLLOWING:</b>			
Congenital conditions / disorders		The abuse of alcohol	
Mental diseases / disorders		Abuse of any drug (not prescribed)	
Chronic defects		Self-inflicted injury	
HIV / AIDS virus/syndrome		Related to pregnancy	
If <b>YES</b> , please elaborate:	<b>YES</b>	<input type="checkbox"/>	<b>NO</b>

**SECTION 3: PATIENT DETAILS**

(to be completed by medical attendant)

Are you the patient's usual medical attendant?			
If <b>NO</b> , please state the details of the usual medical attendant:			
Name:			
Address:			
Telephone number:			
Fax number:			
From date:		To date:	
Is this patient able to perform any part of his/her occupation:			
If <b>YES</b> , please elaborate:			
Is this patient confined to a hospital or bed:			
Please state from:		To date:	
On what date will the patient return to his/her occupation:			
If it is unlikely that the patient will return to his/her usual occupation, please state what part of their usual occupation/employment can now be performed, if any:			

**DETAILS OF MEDICAL ATTENDANT**

Name (in full):			
Telephone number:		Fax number:	
Signature:		Date:	YEAR/MONTH/DAY