

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.

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|---|-----------|
| 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 | |
| | |

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? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 3. Did you treat him/her at any time before the accident? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Head <input type="checkbox"/> Chest <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Back <input type="checkbox"/> Upper limbs <input type="checkbox"/> Lower limbs <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| I/We declare the above particulars are true in every respect. | |
| Name | Qualifications |
| Signature | Date |
| Address | |
| | |
| | |
| Signature of Insured | Date |