Statutory Instrument No. 157 of 1983

MOTOR VEHICLE INSURANCE ACT

(Cap. 69:02)

MOTOR VEHICLE INSURANCE (CLAIM FORM) REGULATIONS, 1983

(Published on 23rd December, 1983)

ARRANGEMENT OF REGULATIONS

IN EXERCISE of the powers conferred on the Minister of Works and Communications by section 25 of the Motor Vehicle Insurance Act, the following Regulations are hereby made —

Citation

1. These Regulations may be cited as the Motor Vehicle Insurance (Claim Form) Regulations, 1983.

Claim form

2. A claim form for —

(*a*) compensation under section 11 shall be in Form I set out in the Schedule hereto; and

(*b*) payment of incidental expenses by a supplier under section 13 shall be in Form II set out in the Schedule hereto.

SCHEDULE

FORM I

CLAIM FOR COMPENSATION UNDER SECTION 11 OF THE MOTOR VEHICLE INSURANCE ACT

(Cap. 69:02)

1. Name of registered company from which compensation is claimed

.....

2. Claimant

(*a*) Full name and address .....

.....

.....

(*b*) Passport number (if any) .....

(*c*) If the claimant claims compensation on behalf of a person(s) other than himself/herself, state:—

(i) Capacity in which claimant is acting .....

(ii) Name and address of person(s) on whose behalf compensation is being claimed .....

(iii) Passport number of such person .....

(iv) Relationship of claimant to such person(s) .....

.....

3. Particulars of motor vehicle insured by the registered company named in paragraph 1:—

(*a*) Name and address of owner .....

.....

.....

(*b*) Registered letters and number .....

(*c*) Insurance Declaration No. (if known) .....

(*d*) Insurance Token No. .....

(*e*) Name and address of driver at time of accident (if known) .....

.....

.....

4. Particulars of accident in which the vehicle described in paragraph 3 was involved:—

(*a*) Date ..... Time .....

(*b*) Place .....

(*c*) Police Station to which reported and Police reference number

(if known) .....

5. Particulars of any other vehicles involved in accident (if known) —

	(i)	(ii)	(iii)
(*a*) Registered letters and number	.....	.....	.....
(*b*) Name of owner	.....	.....	.....
(*c*) Name of driver at time of accident	.....	.....	.....

(*d*) Insurance Declaration No. (if known) .. ..

(*e*) Insurance Token No. ....

(*f*) Name of Insurer .. ..

5. Particulars of person in respect of whose bodily injury or death compensation is claimed:—

(*a*) Full name and address .....

(*b*) Passport number .....

(*c*) Sex .....

(*d*) Date of Birth .....

(*e*) Marital status at date of accident (state whether never married, married, divorced, widowed or legally separated) .....

(*f*) If married, state whether in or out of community of property .....

.....

(*g*) Business or occupation .....

(*h*) At the time of the accident was he/she travelling as a passenger or driver in one of the vehicles described in either paragraph 3 or paragraph 5? (YES or NO.) .....

(*i*) If YES, state registered letters and number of vehicle and whether passenger or driver .....

(*j*) If not travelling as a passenger or driver in one of the vehicles described in either paragraph 3, or paragraph 5 what was his/her mode of conveyance, or was he/she pedestrian .....

(*k*) Name and address of usual medical attendant (if any) .....

.....

(*l*) Names and addresses of all medical practitioners who attended him/her after the accident (if known) .....

.....

.....

(*m*) At which hospital or nursing home or other place, if any, did he/she receive treatment after the accident and for what period? .....

.....

(*n*) Was he/she suffering from any physical defects or infirmities immediately prior to the accident? (YES or NO) .....

(*o*) If YES, give details .....

(*p*) Name and address of employer at date of accident and how long employed. (If more than one employer, state names and addresses of all) .....

.....

(*q*) State his/her income for the 12 months immediately preceding the accident —

(i) from employment .. ..

(ii) from any other source (give details) .. ..

.....

7. If the person named in paragraph 6 was fatally injured 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 has been held? (YES or NO) .....

(*d*) If known state: In what Court .....

date .....

(*e*) Names and addresses of all dependants of the deceased whether or not compensation is being claimed on their behalf under paragraph 8 .....

.....

.....

(*f*) Name and address of the executor of the deceased's estate .....

.....

.....

8. If the person named in paragraph 6 was fatally injured and compensation is claimed by or on behalf of dependants of that person the following information is required in respect of each of such dependants. (If compensation is claimed by or

on behalf of more than one dependant the information required by this paragraph in respect of each dependant should be set out on a separate statement and attached to this form.)

(*a*) Full name and address .....

.....

.....

(*b*) Passport number (if any) .....

(*c*) Sex .....

(*d*) Date of birth .....

(*e*) Relationship to deceased person .....

(*f*) Marital status at date of accident (state whether never married, married, divorced, widowed or legally separated) .....

.....

.....

(*g*) If married, state whether in or out of community of property .....

(*h*) Business or Occupation .....

(*i*) Is he/she suffering from any physical defects or infirmities? (YES or NO) .....

(*j*) If YES, give full particulars .....

.....

(*k*) Name and address of employer at date of accident and how long employed. (If more than one employer, state names and addresses of all) .....

.....

.....

.....

.....

.....

(*l*) State his/her income for the 12 months immediately preceding the accident —

(i) from employement .. ..

(ii) from any other source (give details) .....

.....

.....

(*m*) Details and amount of any inheritance of any other benefits received from the estate of the deceased or accruing from any other source as a result of the death of the person referred to in paragraph 6, e.g. proceeds of life and endowment policies .....

.....

.....

(*n*) Amount received annually by way of any pension or pensions .....

.....

9. Compensation claimed:—

(*a*) Precise details must be given in respect of each of the following items and supported by vouchers where applicable.

(If necessary, the information required by this section may be set out on a separate statement duly signed and attached to this form)

Item	*Amount*
(i) Medical and hospital expenses	P .....
(ii) Estimated future medical and hospital expenses	P .....
(iii) Loss of earnings (from date of accident to date hereof)	P .....
(iv) Estimated future loss of earnings	P .....
(v) General damages for pain and suffering, loss of the amenities of life, etc. (specify)	P .....
Total	P .....

(*b*) Is the claimant entitled to recover, or has the claimant already recovered, any amount from any other source, e.g. Employer, Medical Aid Society or Fund, or under the Workmen's Compensation Act, 1977, (Act No. 43 of 1977)? (YES or NO) .....

.....

(*c*) If YES, give full details .....

(*d*) If the claimant is entitled to claim under the Workmen's Compensation Act, 1977, has the Workmen's Compensation Commissioner been notified that a claim is being lodged with the Registered Company named in (1) above? (YES or NO) .....

(*e*) If YES, give date of notification and by whom given .....
I hereby declare that to the best of my knowledge and belief all the information contained in this form in true and correct.

Signed at .....this.....day of..... , 19.....

Signature of claimant (named in paragraph 2 or his/her authorized representative). (If the above signature is not that of the claimant, state the capacity in which the authorized representative is acting.)

I hereby certify that this affidavit was signed and sworn to/affirmed before me

at .....

this ..... day of..... , 19.....
the deponent having acknowledge that he/she knows and understands the contents of this Affidavit.

.....
Commissioner of Oaths

Area: .....

Capacity: .....

MEDICAL REPORT

(Where blocks are provided for the purpose of a reply to a question place a cross in the applicable block)

1. Are you satisfied that the person to whom this report relates is the person named in paragraph 6 of the claim form?

YES ☐ NO ☐

2. Date when first seen after accident .....
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. Are the injuries —

Minor? ☐ Moderately Severe? ☐ Severe? ☐

5. Indicate the parts of the body injured:—

Head ☐ Chest ☐ Neck ☐ Abdomen ☐ Back ☐

Upper Limbs ☐ Lower ☐ Pelvis ☐

6. Give full details of the nature of the injuries and any complications (e.g. Fractured ribs with haemothorax, Compound fracture left tibia, Disfigurement, etc.) and treatment to date .....

7. Is permanent disability anticipated?

YES ☐ NO ☐

If YES, give full details .....

If NO, has his/her condition become stabilized? .....

8. Is Specialist treatment being given?

YES ☐ NO ☐

IF YES, give name and address of Specialist .....

.....

9. Give full details of nature and anticipated duration of any future treatment ...

10. Have the injuries been aggravated by any pre-existing pathological condition?

YES ☐ NO ☐

11. Has any such pre-existing pathological condition been aggravated by effects of trauma?

YES ☐ NO ☐

12. If the answer to either 10 or 11 is YES, give full details .....

.....

13. Has there been any confinement to hospital/nursing home?

YES ☐ NO ☐

If YES, state name and address of hospital/nursing home and date when released or when release is expected .....

14. If in employment at date of accident, state date when return to employment is expected .....

15. Where there has been a fatal termination, indicate: —
(*a*) Date of death .....

(*b*) Cause .....

(*c*) Did any pre-existing pathological condition contribute to death?

YES ☐ NO ☐

(*d*) If YES, give full details .....

Name of medical practitioner .....

Signature .....

Qualifications .....

address .....

.....

Date .....

FORM II

CLAIM BY SUPPLIER FOR INCIDENTAL EXPENSES UNDER SECTION 13 OF THE MOTOR VEHICLE INSURANCE ACT (CAP. 69:02)

1. Name of registered company against which claim is made .....

2. Supplier:—
(*a*) Full name and address .....

.....

(*b*) If supplier is a medical or dental practitioner, state:—

(i) Registered qualifications .....

(ii) Whether general practitioner or registered specialist .....

.....

(iii) Full name of injured Third Party who received or is receiving treatment

.....

.....

(iv) Names of all hospitals or other institutions in which Third Party was or is being treated .....

.....

(v) Nature of injuries sustained by Third Party .....

.....

(vi) Dates, duration and nature (including surgical operations) of treatment rendered .....

.....

(vii) Amount claimed for services rendered (specify) .....

.....

(viii) Amount claimed for materials supplied and actually used in treatment (give details) .....

(ix) If amounts referred to in sub-paragraphs (vii) and (viii) above are also being claimed from any other registered company, give details .....

.....

(*c*) If supplier is a hospital or nursing home state:—

(i) Full name of injured Third Party receiving treatment .....

.....

(ii) Name of hospital(s) or nursing home(s) where treatment was or is being rendered .....

(iii) Hospital reference number .....

(iv) Period of treatment in hospital(s) or nursing home(s) in respect of which claim is made:

from ..... to .....

P t

(v) (i) Number of days at ..... per day .....

(ii) Out-patient treatment

at .....each .....

(iii) Operating theatre ....

(iv) Other (specify) ....

....

....

....

....

Total .. .. P .....

(*d*) If supplier is a pharmacist or other supplier of goods to the Third Party, state:—

(i) Full name of Third Party to whom goods were supplied

.....

.....

(ii) Name of pharmacist .....

(iii) Date and details of goods supplied (specify):—

.....

....

....

.....

Total .. .. .. P .....

(*e*) If supplier is a nurse, state:—

(i) Full Name of Third Party who received treatment and/or services ...

(ii) Name of nurse and registered qualifications .....

.....

(iii) Date and duration of treatment and/or services rendered .....

(iv) Details of treatment and/or services rendered (specify):—

..... P .....

..... P .....

..... P .....

..... P .....

Total .. .. P .....

3. Particulars of motor vehicle insured by the registered company named in paragraph 1 (if known):—
(*a*) Name and address of owner .....

(*b*) Registered letters and number .....

(*c*) Insurance Declaration No. .....

(*d*) Insurance Token No. .....

(*e*) Name and address of driver at time of accident .....

4. Particulars of accident in which the vehicle described in paragraph 3 was involved (if known):—
(*a*) Date ..... Time .....

(*b*) Place .....

(*c*) Police Station to which reported .....

.....
Signature of supplier.

MADE this 13th day of December, 1983.

C.W. BLACKBEARD,
Minister of Works and Communications.

L2/7/91