OMSMAF
OLD MUTUAL STAFF MEDICAL AID FUND

Administered by Universal Healthcare (Pty) Ltd
Universal House, 15 Tambach Road, Sunninghill Park, Sandton, 2191
PO Box 1411, Rivonia, 2128, South Africa
Tel +27 (11) 208 1000, Fax +27 (11) 208 1128
www.universal.co.za

Motor Vehicle Accident Questionnaire

Please complete in BLOCK LETTERS using black or blue ink.

This form is issued without admission of liability and must be signed by the claimant and forwarded to:

Old Mutual Service Centre

Tel	0860 100 076 / +27 11 208 1021
E-mail	claims@omsmaf.co.za
Fax number	0860 106 635
Postal Address	Old Mutual Staff Medical Aid Fund, PO Box 1411, Rivonia, 2128

INFORMATION

When you are involved in a motor accident where a third party is liable and you have recourse in terms of a third-party claims, you are required to institute a claim against the third-party which the Fund can assist with, if you provide the necessary information. When the claim is finalised and paid to you, you are responsible to refund the Fund for payments made on your behalf while the third-part claim was finalised. Failure to do so, constitutes unlawful enrichment and the Fund will reverse claims payments made in respect of the injury/event which will leave you personally responsible to pay the claims.

MEMBER DETAILS

Title:

Member name:

Member surname:

Membership number:

Contact numbers: H Cell

W Fax

Email address:

CLAIMANT AND INJURED PERSON'S DETAILS

Name of injured person:

Surname:

Identity number:

Claimant identity number:

Relationship to member:

Date: (DD/MM/YYYY) Place:

Type of injury sustained:

Police station where accident was reported:

EXPLAIN BRIEFLY HOW ACCIDENT OR INJURY OCCURRED

ATTORNEY DETAILS

Attorney name:

Contact numbers: Tel: Fax:

Address details:

THIRD PARTY DETAILS

Please indicate from which 3rd party will be claimed:

Road accident fund: ☐ Yes ☐ No

Insurance claim: ☐ Yes ☐ No

Any other source:

Personal claim: ☐ Yes ☐ No

INJURIES ON DUTY CLAIMS

Injuries sustained while on duty will not be covered by the medical Fund. Please consult your manager or HR department regarding an employer's accident report (wcl.2 form).

Signed at (PLACE)

Date: (DD/MM/YYYY)

Signature of patient