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BOARD NOTICE 58 OF 2021

ROAD ACCIDENT FUND

STIPULATION OF TERMS AND CONDITIONS UPON WHICH CLAIMS FOR THE COMPENSATION SHALL BE ADMINISTERED

The Road Accident Fund hereby, in accordance with section 4(1)(a) of the Road Accident Fund Act, No. 56 of 1996, stipulates the terms and conditions upon which claims for compensation shall be administered, as set out in the Schedule hereto.

SCHEDULE

1. In this Schedule "the Act" means the Road Accident Fund Act, No. 56 of 1996.

2. In order to enable Fund to effectively and efficiently administer claims, and in addition to the documentation required in terms of the Act to ensure that a valid claim is lodged which substantially complies with the Act, the following documents must be included and form part of the claim's supporting documents when lodging the claim with the Fund:

2.1 Standard documentation applicable to both death and injury benefits:

2.1.1 Certified Copies of Identity Documents
2.1.2 Accident Report Form, Case docket and sketch plan
2.1.3 Power of Attorney and Contingency Fee Agreement
2.1.4 Permission for the Fund to obtain and inspect hospital and medical records in terms of s19(e)(ii) and 19(e)(iii)
2.1.5 All statements and documents in claimant's possession as outlined in S19(f)(ii)
2.1.6 When the claimant is claiming in the capacity as guardian of a minor or for loss of support, copies of the unabridged birth certificate must accompany the claim form.
2.1.7 If it is a Curator submitting a claim, certifed copy of Court order/Masters' letters of appointment

2.2 Claims administration requirements for death benefits claims

2.2.1 Funeral Claim

2.2.1.1 Death certificate
2.2.1.2 Proof of the relationship of claimant to deceased (certified marriage certificate/ unabridged birth certificate/Affidavit confirming relationship)
2.2.1.3 Post - mortem report
2.2.1.4 A tax invoice for funeral expenses with proof of payment

2.2.2 Loss of support

2.2.2.1 Certified copy of deceased's ID
2.2.2.2 Certified copy of death certificate
2.2.2.3 Curatorship: Certified copy of court order/Letters of appointment
2.2.2.4 Certified copy of marriage certificate/certificate proving customary marriage/un-abridged birth certificate
2.2.2.5 If not married, an affidavit setting out the legal basis of claimant's dependency on deceased
2.2.2.6 Deceased's medical and hospital records, if applicable
2.2.2.7 Specified vouchers for medical costs if claimed
2.2.2.8 Post-mortem report/ Inquest record/charge sheet/other documents proving that the deceased was killed in the accident
2.2.2.9 Employer's certificate of deceased's service showing nature of employment, the period of service, remuneration, prospects of advancement and compensation and retirement age
2.2.2.10 Deceased's Payslips

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2.2.2.11 Deceased's tax records (if not available, communication from SARS that Claimant is not registered for tax) in which case a bank statements for three years preceding death will be required.
2.2.2.12 Proof of any additional income, if applicable
2.2.2.13 Copy of Liquidation and Distribution account
2.2.2.14 Copy of maintenance order, if applicable
2.2.2.15 The child support grant official documents, if applicable
2.2.2.16 Employer's certificate of spouse indicating the period of employment, remuneration and advancement prospects
2.2.2.17 Official confirmation of the Compensation Fund's award if deceased died during the course and scope of employment
2.2.2.18 Actuarial report

2.3 Claims administration requirements for injury benefits claims

2.3.1 Past Medical Expenses

2.3.1.1 An itemised tax invoice from a registered medical provider or hospital for past medical expenses, together with proof of payment

2.3.2 Loss of earnings

2.3.2.1 Copies of all medical and hospital records, including photographs of the injuries
2.3.2.2 Employer's certificate showing nature of employment, the period of employment, remuneration, prospects of advancement and retirement age
2.3.2.3 Proof of any other income, if applicable
2.3.2.4 Claimant's tax records (if not available, communication from SARS that Claimant is not registered for tax) in which case a bank statements for three years preceding death will be required.
2.3.2.5 Payslips pre and post-accident
2.3.2.6 Copies of all hospital and medical records in terms of s 19(e)(i) and 19(e)(ii)
2.3.2.7 Copies of all hospital and medical accounts
2.3.2.8 Medical reports or documentation establishing or substantiating claimant's temporary/permanent disability and the loss of earnings claimed
2.3.2.9 Official confirmation of remuneration/compensation received from other sources
2.3.2.10 Official documentation confirming any disability grant
2.3.2.11 Official confirmation of the Compensation Fund's award if claimant was injured during the course and scope of employment.

2.3.3 General damages

2.3.3.1 Duly compeleted RAF 4 FORM
2.3.3.2 Copies of all hospital and medical records in terms of s 19(e)(i) and 19(e)(ii)
2.3.3.3 Medical reports
2.3.3.4 Photographs of injuries or scarring, where applicable

2.4 Mandatory information / documentation to be submitted for claims payments

2.4.1 To ensure that payments are processed in line with the settlement agreements concluded and/ in compliance with court orders, the following documents must accompany any request for payment:

2.4.1.1 Stamped Court Order/duly signed discharge form or settlement agreement:
2.4.1.2 Duly signed Power of Attorney
2.4.1.3 Tax clearance certificate, which shall be submitted by the claimants' attorneys at least once a year.
2.4.1.4 Proof of banking details / confirmation of Banking Details (Trust Account).
2.4.1.5 Copy of the Contingency Fee Agreement concluded with the claimant and Proof of compliance with section 4 of the Contingency Fee Act, alternatively, the attorney must submit an affidavit to confirm that there is no contingency fee agreement.

3. These terms and conditions took effect on 01 April 2021

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ROAD ACCIDENT FUND

SUBSTITUTION OF RAF 1 CLAIM FORM

The Road Accident Fund hereby, in accordance with Regulation 7(1) of the Road Accident Fund Regulations, 2008, published under Government Notice No. 770 of 21 July 2008 in Government Gazette No. 31249, substitutes the RAF 1 Claim Form as set out in the Schedule.

SCHEDULE

1. In this Schedule "the Act" means the Road Accident Fund Act, No. 56 of 1996.

2. A claim for compensation and accompanying medical report referred to in section 24 (1) (a) of the Act, must be in the form of the RAF 1 form, prescibed as follows:

   [insert claim form]

3. A claim for compensation and accompanying medical report referred to in section 24 (1) (a) of the Act, which is not in the form of the RAF 1 form in paragraph 2 shall not be acceptable by the Fund as a claim.

4. Claimants are directed to make use of the substituted RAF 1 form in paragraph 2, as the old RAF 1 form will not be aceptable as the prescribed claim form.

5. The effective date of the substitution of the RAF 1 form is the date of publication of this Notice in the Gazette.

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Important information

a. This is a prescribed form to be completed in respect of claims for compensation under section 17 of the Road Accident Fund (RAF) Act, provided for in terms of section 24(1)(a) of the Act.

b. This form shall be completed in all its particulars and in instances where there are asterisks indicating that supporting documents will be required, such must be included for completeness.

c. Your attention is drawn to the provisions of section 24(4)(a) of the Act, which provides that any form referred to in the section which is not completed in all its particulars shall not be acceptable as a claim under the Act.

d. Please take note that when a form submitted to the Fund is not completed in all its particulars and not acceptable as a claim, the provisions of section 24(1)(b) shall not be invoked, and the Fund shall not be obliged to acknowledge receipt thereof.

e. The form and relevant supporting documents can be sent to us via our regional offices or by registered mail.

f. This form consists of three sections: Section A, B and C.

g. Complete Section A and B if lodging an Injury Benefit Claim and Section A and C for a Death Benefit Claim.

Section A

(Personal Information and Accident Details)

1. Capacity

Unrepresented		
Represented	**Attach proof of contingency fee agreement and power of attorney*	

1.1 Details of Legal Representative

Representative's Name and Surname	
Representative Capacity	
Name of Firm	

1.2 Bank Account Details of Claimant / Legal Representative

Bank Name	
Branch Number	
Name of Account Holder	

2. Personal Information

2.1 Personal Details of the Claimant

Title		**Name and Surname**	
ID Number / Passport Number	** Attach a certified copy of ID or passport*	**Date of Birth**	
Residential Address	Town		
	Province		
	Postal Code		
Postal Address	Town		
	Province		
	Postal Code		
Home Telephone Number		**Work Telephone Number**	
Cell Phone Number		**Email**	

Preferred Method of Communication	✓	Email	SMS	Post	Tel /Cell
Home / Preferred Language of Communication					
Country of Residence					

Ethnicity / Race			**Country of Birth**		
Sex	✓	Male		Female	
Marital Status					
Residential Country					

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2.2 Personal Details of the Injured (complete only if the claimant is not the injured)							
Title		Name and Surname					
Date of Birth		ID Number / Passport Number	* Attach a certified copy of ID, unabridged birth certificate or passport				
Residential Address		Complex					
		Street					
		Town					
		Province					
		Postal Code					
Postal Address		Postal Box					
		Street					
		Town					
		Province					
		Postal Code					
Home Telephone Number			Work Telephone Number				
Cell Phone Number			Email				
Preferred Method of Communication		✓	Email	SMS	Post	Tel /Cell	
Home / Preferred Language of Communication			Marital Status				
Ethnicity / Race			Country of Birth				
Residential Country							
Sex	✓	Male		Female			

2.3 Personal Details of the Deceased					
Title		Name and Surname			
Date of Birth		Date of Death	* Attach a certified copy of death certificate		
Residential Address		Complex			
		Street			
		Town			
		Province			
		Postal Code			
Time of Death		ID Number /	* Attach a certified copy of ID or passport		
		Passport Number			
Country of Birth					
Residential Country					
Sex	✓	Male	Female		

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2.4 Personal Details of Dependants: No.1	
Title	
Name and Surname	
Date of Birth	
ID Number / Passport Number	** Attach a certified copy of ID, Unabridged birth certificate*
Ethnicity / Race	
Country of Birth	
Residential Country	
Sex (Male/Female)	
Relationship to the Deceased	
Reason for Dependence	
Marital Status	

2.4 Personal Details of Dependants: No. 2	
Title	
Name and Surname	
Date of Birth	
ID Number / Passport Number	** Attach a certified copy of ID, Unabridged birth certificate*
Ethnicity / Race	
Country of Birth	
Residential Country	
Sex (Male/Female)	
Relationship to the Deceased	
Reason for Dependence	
Marital Status	

2.4 Personal Details of Dependants: No. 3	
Title	
Name and Surname	
Date of Birth	
ID Number / Passport Number	** Attach a certified copy of ID, Unabridged birth certificate*
Ethnicity / Race	
Country of Birth	
Residential Country	
Sex (Male/Female)	
Relationship to the Deceased	
Reason for Dependence	
Marital Status	

2.4 Personal Details of Dependants: No. 4	
Title	
Name and Surname	
Date of Birth	
ID Number / Passport Number	** Attach a certified copy of ID, Unabridged birth certificate*
Ethnicity / Race	
Country of Birth	
Residential Country	
Sex (Male/Female)	
Relationship to the Deceased	
Reason for Dependence	
Marital Status	

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2.5 Next of Kin Details					
Title		**Name and Surname**			
Home Telephone Number			**Work Telephone Number**		
Cell Phone Number			**Email**		
Relationship to Claimant/Injured					
Sex	✓	Male		Female	

3. Accident Details		
3.1 Motor Vehicle Accident Details		
Date of Accident		
Time of Accident		
Place of Accident	Street	
	Town	
	Province	
	Postal Code	
Name and Address of Police Station Where the Accident was Reported	Name	
	Town	
	Province	
	Postal Code	
Contact Details of SAPS Station		** Attach SAPS Accident Report*
Name of Investigating Officer		** Attach a docket*
Accident Report Number (AR Number)		
Case Reference Number (CR Number)		
Post-mortem Results Relating to the Deceased		** Post mortem report (for death claims only)*
Accident Notification - RAF 3 Form Reference Number		
** Attach accident report or copy of the case docket or both documents in case of death*		

3.2 Injured/Deceased Capacity						
Capacity in Accident ✓	Pedestrian	Passenger		Cyclist		
	Driver		Motorcyclist			
Vehicle Registration Number						
Driver's Name and Surname						
Vehicle Make and Model						
Please Indicate if This is a Public Transport Vehicle		Yes		No		
Driver's Physical Address	Complex					
	Street					
	Town					
	Province					
	Postal Code					
Driver's Cell Phone Number						

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To be completed where the injured or deceased was a pedestrian or cyclist

3.3 Accident Scenarios of Pedestrians' and Cyclists' Details	
Crossing a road with poor visibility and obstructed view of oncoming traffic	✓
Crossing the road at a robot-controlled intersection/pedestrian crossing/robot-controlled pedestrian crossing	
Crossing in front of or behind a stationary vehicle	
Crossing a highway	
Running/cycling across the road	
Pedestrian standing on the centre line/painted island/centre island	
Pedestrian under seven years of age	
Pedestrian between seven and 14 years of age	
Other (Specify)	

To be completed where the injured or deceased was a driver or motorcyclist

3.4 Driver / Motorcyclist				
Vehicle Registration Number				
Vehicle Owner's Name & Surname				
Vehicle Owner's Telephone Number				
Vehicle Owner's Cell Phone Number				
Vehicle Owner's Physical Address	Complex			
	Street			
	Town			
	Province			
	Postal Code			
Driver's Licence number				**Attach certified copy of driver's licence*
Category of Licence and Restrictions				
Date of Issue				
Valid	From		To	
Insurance Details (Include All Details of Claim)				

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3.5 Accident Scenarios of a Driver or Motorcyclist	✓ or not applicable
Head-on collision	
Rear-end collision	
Stop-street-controlled intersection (4-way stop, T-junction, opposing stop streets)	
Robot-controlled intersection	
Tyre burst	
Collision with animal	
Single-vehicle accident	
Accident with object	
Poor visibility/dust cloud/smoke	
Right turn	
Overtaking	
Lane change	
T-junction	
Merging/ joining/yield sign	
Traffic circle	
Stationary vehicle	
Reversing	
Other (Specify)	

3.6 Details of Other Vehicle(s) Involved in the Accident					
Vehicle Registration Number	*All vehicles involved*				
Vehicle Make and Model					
Driver's Contact Details	*All vehicles involved*				
Unidentified Motor Vehicle		Yes		No	
Please indate if any of the vehicles is a public transport vehicle					
3.7 Witnesses					
Any Witnesses to the Accident?	*If yes, attached the witness statement(s)*	Yes		No	
Witness's Name and Surname					
Witness's Address					
Witness's Telephone Number					
Witness's Cell Phone Number					
3.8 Safety Measures					
Seatbelt/Helmet worn at time of accident?		Yes		No	
Blood alcohol tested?		Yes		No	
Results	*If yes, attach results*		*Attach results*	Yes	No

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Section B
Injury Benefits Claim

4. Benefits Claimed		
Past Loss of Earnings	R ____________	*Medical Reports and proof of income
Future Loss of Earnings	R ____________	*Medical Reports and proof of income
General Damages	R ____________	*Medical and hospital records and serious injury assessment
Past Medical Expenses	R ____________	*Specified vouchers and proof of payment
Future Medical Expenses	R ____________	*Medical Reports

5. Employment Information

5.1 Details of Injury on Duty Claims (If applicable)		
MVA under Compensation for Occupational Injuries and Diseases Act	Yes	No
Claim Lodged with the Compensation Fund?	Yes	No
Compensation Fund Reference Number		
Amount Received		
Final Award **Attach final award*	Yes	No

5.2 Employment Status				
Status	✓	Employed	Self-Employed	Unemployed

Employment Sector Category	✓ *or not applicable*
Self-employed	
Public Servant	
Formal Regulated Industry	
Informal Unregulated Industry	

Employment Sector	
Agriculture, Food and Natural Resources	
Architecture and Construction	
Arts, Audio/Video Technology and Communications	
Business Management and Administration	
Education and Training	
Finance	
Government and Public Administration	
Health Science	
Hospitality and Tourism	
Human Services	
Information Technology	
Law, Public Safety, Corrections and Security	
Manufacturing	
Marketing, Sales and Service	
Science, Technology, Engineering and Mathematics	
Transportation, Distribution and Logistics	
Other (Specify)	

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5.3 Employment Details	
Occupation	
Annual Remuneration (pre- and post-accident)	
Highest Qualification and NQF Level	
Was the injured required to take time off duty?	
If yes, please specify the dates	
Number of work days absent	
Did you receive any remuneration while away from work?	
State amount received	
Nature of payment received	

5.4 Employer's Details				
Name of Employer				
Physical Address				
Telephone Number				
Contact Person				
Employee Number				
Nature of Employment	✓	Permanent	Temporary	Casual / Contract
Period of Temporary / Contract / Casual Employment				

5.5 Proof of Income				
Payslips	*	Tax Return	*	Declaration to give RAF consent to validate any income
Printout of Payments from Employer	*	Bank Statements	*	
Other (Specify)	*			
Tax Reference Number	*			
				*attach proof of items marked with an **

5.6 Self-Employed				
Business Name				
Nature of Business				
Business Address				
Legal Entity of Business	✓	Sole Trader	Partnership	Trust
		Company	Close Corporation	Other

5.7 Minor's Injury Claims		
Level of education at the time of accident		
Age at the time of accident		
Level of education at the time of submitting the claim		
Age at the time of submitting the claim		
School /university report pre-accident	** minimum three years' report*	
School /university report post-accident		

6. Injury Details	
Type(s) of Injuries	
Severity of Injuries	
List of Injuries	
Hospital	
Address of Hospital	
Person who treated the injured	

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6.1 Substantial Compliance Injury Claims		✓ or not applicable
Standard documents		
i.	Statutory Medical Report	
ii.	Copies of all Hospital and Medical Records in terms of section 19 (e) (i) and 19 (e) (ii)	
ii.	Amount Claimed as Compensation	
iii.	Certified copy of Claimant's ID	
iv.	Certified copy of Injured's ID (if different from claimant)	
v.	Unabridged birth certificate (if a natural guardian is claiming on behalf of a minor). If it's the legal guardian claiming on behalf of a minor they must submit a court order.	
vi.	Officer's Accident Report	
vii.	Docket and Sketch Plan	
viii.	Consent for RAF to obtain and inspect hospital and medical records in terms of section 19 (ii) and 19 (e) (iii)	
ix.	Consent for RAF to obtain and inspect financial and earnings information	
x.	Court Order or Master's letter of appointment (If Curator submitting on behalf of minor – (If applicable)	
xi.	Power of Attorney (if Represented)	
xii.	Contingency Fee Agreement (if Represented)	
xiii.	Affidavit in terms of Section 19 (f) (i)	
xiv.	Any other statements/documents in accordance with section 19 (f) (ii)	
General Damages		
i.	Photographs of injuries or scarring, where applicable	
ii.	RAF 4 Form for serious injury report duly completed in line with American Medical Association (AMA) guides	
iii.	Narrative test where applicable	
Loss of Earnings		
i.	RAF 4 Form where applicable	
ii.	Employer's certificate showing nature of employment, the period of service, remuneration, prospects of advancement and retirement age	
iii.	Proof of any other income (If applicable)	
iv.	Claimant's tax records (if not available, communication from SARS that the claimant is not registered for tax), in which case a bank statement for three years preceding the accident must be submitted	
v.	Payslips pre- and post-accident	
vi.	Academic records	
vii.	Medical reports or documentation establishing or substantiating claimant's temporary/ permanent disability and the loss of earnings claimed (Medico-legal reports)	
viii.	Official confirmation of remuneration / compensation received from other sources	
ix.	Official documentation confirming any disability grant	
x.	Official confirmation of the Compensation Fund's award (if the claimant was injured during the course and scope of employment)	
Past Medical Expenses		
i.	An itemised tax invoice from a registered medical provider/or hospital for past medical expenses	
ii.	Proof of payment of medical expenses	

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7. Medical Report

Section 24(2)(a) provides that this report shall be completed by the medical practitioner who treated the injured or deceased person for the bodily injuries sustained by him/her in the accident, from which this claim arises or by the superintendent (or his representative) of the hospital in which the injured or deceased person was treated for such bodily injuries. (ii) Where blocks are provided for the purpose of replying to a question, place a cross in the appropriate block.

Patient's Name and Surname	
Patient's ID Number	
Patient's Date of Birth	
Have you verified that this is the person mentioned in the injured section of the claim form using an ID or a Passport	
Date when first seen after the accident	
Did you treat the patient at any time before?	
If yes, give date of last such treatment and nature of correct ailment	
Give full details of the nature of the injuries and any complications (e.g. fractured rib with haemothorax, contusion of the heart, compound fracture, etc.)	

Parts of body injured and degree

	Head	Central Nervous System	Chest	Neck	Abdomen	Back	Upper Limbs	Lower Limbs	Pelvis	Musculo-skeletal & skin
Minor										
Moderate										
Severe										

ICD 10 CODE	PROCEDURE	TREATMENT PLAN

7.1 Level of Care and Duration

Level of care	Duration
ICU	
High Care	*Attach any clinical notes
Ward	
Step-down / Rehabilitation	

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Any other treatment given to date?		
Is there any current or future permanent disability?	Yes	No
If yes, provide details		
If no, has the condition stabilised?		
Is there any future/ongoing medical treatment, e.g. specialist, physiotherapy, etc.?	Yes	No
If yes, provide name and address of treating service provider		
Any other treatment given to date?	Yes	No
Is there any current or future permanent disability?	Yes	No
If yes, provide details		
If no, has the condition stabilised?		
Is there any future/ongoing medical treatment, e.g. specialist, physiotherapy, etc.?	Yes	No
If yes, provide name and address of treating service provider		
What is the nature of such treatment?		
Is hospitalisation foreseen in connection with future treatment referred to above?	Yes	No
What are the pre-existing conditions?		
Have the injuries aggravated any pre-existing pathological condition?	Yes	No
If yes, please give details		
Have any such pre-existing pathological conditions aggravated the effects of trauma?	Yes	No
If yes, please give details		
Has the patient been confined to a hospital/rehab centre/ stepdown facility?	Yes	No
Date of admission		
Name and address and practice number of facility		
Hospital reference number		
Date of discharge or when discharge is expected		
If in employment at date of accident, state date when return to employment is expected		
7.2 Medical Report - Medical Practitioner's Details		
Name and Surname		
Speciality		
Practice Number Health Professions Council of South Africa (HPCSA) and/or Board of Healthcare Funders (BHF)		
Telephone Number		
E-mail Address		
Cell Phone Number		
Postal Address		
Physical Address		

Signature		Affix Stamp (If applicable)
Date		

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Section C
Death Benefit Claim

8. Benefits Claimed		
Funeral Expenses	R ______________	*Specified Voucher (Tax invoice for funeral expenses)
Past Loss of Support	R ______________	*Proof of Income
Future Loss of Support	R ______________	*Proof of Income
Past Medical Expenses	R ______________	*Specified vouchers and proof of payment

9. Employment Information		
9.1 Details of Injury on Duty Claims (If applicable)		
MVA under Compensation for Occupational Injuries and Diseases Act	Yes	No
Claim Lodged with the Compensation Fund?	Yes	No
Compensation Fund Reference Number		
Amount Received		

9.2 Deceased Employment Status				
Status	✓	Employed	Self-Employed	Unemployed
Employment Sector Category				✓ or not applicable

Self-employed	
Public Servant	
Formal Regulated Industry	
Informal Unregulated Industry	

Employment Sector	
Agriculture, Food and Natural Resources	
Architecture and Construction	
Arts, Audio/Video Technology and Communications	
Business Management and Administration	
Education and Training	
Finance	
Government and Public Administration	
Health Science	
Hospitality and Tourism	
Human Services	
Information Technology	
Law, Public Safety, Corrections and Security	
Manufacturing	
Marketing, Sales and Service	
Science, Technology, Engineering and Mathematics	
Transportation, Distribution and Logistics	
Other (Specify)	

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Final Award			*Attach final award	Yes	No
10. Deceased's Employment Details					
10.1 Deceased's Employment Details					
Occupation					
Annual Remuneration (Pre- and Post-Accident)					
Highest Qualification and NQF Level					
10.2 Deceased's Employer's Details					
Name of Employer					
Postal Address					
Telephone Number					
Contact Person					
Employee Number					
Nature of Employment	✓	Permanent	Temporary	Casual / Contract	
Period of Temporary / Contract / Casual Employment					
10.3 Deceased's Proof of Income					
Payslips	*	Tax Return	*	Declaration to give RAF consent to validate any income	
Printout of Payments from Employer	*	Bank Statements	*		
Other (Specify)	*				
Tax Reference Number	*				
*attach proof of items marked with an **					
10.4 Self-Employed Deceased					
Business Name					
Nature of Business	✓				
Business Address					
Legal Entity of Business	Sole Trader	Partnership	Trust		
	Company	Close Corporation	Other		
10.5 Employment Details of the Surviving Spouse					
Occupation					
Employer					
Annual Renumeration					
Payslip					
Tax Reference Number					
Declaration to give RAF consent to validate any income					
11. Injury Details (Only Where the Deceased Did Not Die at the Scene)					
Type(s) of Injuries					
Severity of Injuries					
List of Injuries					
Hospital					
Address of Hospital					
Person who treated the deceased					

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11.1 Substantial Compliance Death Claims		✓ or not applicable
Standard documents		
i.	Completed Statutory Medical Report (Only applicable if the deceased did not die at the scene)	
ii.	Hospital and medical records (Only applicable if the deceased did not die at the scene)	
iii.	Amount claimed as compensation	
iv.	Certified copy of the claimant's ID	
v.	Certified copy of the dependant's ID	
vi.	Certified copy of the deceased's ID	
vii.	Certified copy of death certificate	
viii.	Unabridged birth certificate (if a natural guardian is claiming on behalf of a minor). If it's the legal guardian claiming on behalf of a minor they must submit a court order.	
ix.	Officer's Accident Report	
x.	Docket and Sketch Plan	
xi.	Court Order or Master's letter of appointment (If Curator submitting on behalf of minor – (If applicable)	
xii.	Power of Attorney (if Represented)	
xiii.	Contingency Fee Agreement (if Represented)	
xiv.	Affidavit in terms of Section 19 (f) (i)	
xv.	Any other statements/documents in accordance with section 19 (f) (ii)	
xvi.	Post-mortem/ Inquest Report/Charge sheet and/or any other document(s) proving that the deceased was killed in the collision or as a result of the collision	
Funeral		
i.	Specified Voucher (Tax invoice for funeral expenses)	
ii.	Proof of Payment of funeral expenses	
iii.	Proof of relationship to the deceased (certified marriage certificate/unabridged birth certificate/ affidavit confirming relationship)	
Loss of Support		
i.	Certified copy of marriage certificate/Certificate proving customary marriage/unabridged birth certificate	
ii.	If not married, an affidavit setting out the legal basis of the claimant's dependency on the deceased	
iii.	Employer's certificate of the deceased's service showing nature of employment, the period of service, remuneration, prospects for advancement and compensation and retirement age	
iv.	Payslips	
v.	Copy of maintenance order, if any	
vi.	Claimant's tax records (if not available, communication from SARS that the claimant is not registered for tax, in which case a bank statement for three years preceding death must be submitted)	
vii.	Proof of additional income (if applicable)	
viii.	Copy of Liquidation and Distribution Account (if applicable)	
ix.	Employer's certificate of surviving spouse indicating period of employment, remuneration and prospects for advancement	
x.	Proof of guardianship (if claimant not biological parent)	
xi.	Proof of academic registration for children or dependants	
xii.	Actuarial Report	
xiii.	All payments in terms of Compensation Commissioner, Rand Mutual, Police, Defence Force, etc.	
Past Medical Expenses		
i.	An itemised tax invoice from a registered medical provider/or hospital for past medical expenses	

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12. Medical Report (Only Applicable Where the Deceased Did Not Die at the Scene)	
Section 24(2)(a) provides that this report shall be completed by the medical practitioner who treated the injured or deceased person for the bodily injuries sustained by him/her in the accident, from which this claim arises or by the superintendent (or his representative) of the hospital in which the injured or deceased person was treated for such bodily injuries. (ii) Where blocks are provided for the purpose of replying to a question, place a cross in the appropriate block.	
Patient's Name and Surname	
Patient's ID Number	
Patient's Date of Birth	
Have you verified that this is the person mentioned in the injured section of the claim form using ID or passport	
Date when first seen after the accident	
Did you treat the patient at any time before?	
If yes, give date of last such treatment and nature of correct ailment	
Give full details of the nature of the injuries and any complications (e.g. fractured rib with haemothorax, contusion of the heart, compound fracture, etc.)	

Parts of body injured and degree

	Head	Central Nervous System	Chest	Neck	Abdomen	Back	Upper Limbs	Lower Limbs	Pelvis	Musculo-skeletal & skin
Minor										
Moderate										
Severe										

ICD 10 CODE	PROCEDURE	TREATMENT PLAN

12.1 Level of Care and Duration

Level of care	Duration
ICU	
High Care	**Attach any clinical notes*
Ward	
Step-down / Rehabilitation	

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12.1 Medical Report (Continued)		
Any other treatment given to date?		
Is there any current or future permanent disability?	Yes	No
If yes, provide details		
If no, has the condition stabilised?	Yes	No
Is there any future/ongoing medical treatment, e.g. specialist, physiotherapy, etc.?	Yes	No
If yes, provide name and address of treating service provider		
Any other treatment given to date?		
Is there any current or future permanent disability?	Yes	No
If yes, provide details		
If no, has the condition stabilised?		
Is there any future/ongoing medical treatment, e.g. specialist, physiotherapy, etc.?	Yes	No
If yes, provide name and address of treating service provider		
What is the nature of such treatment?		
Is hospitalisation foreseen in connection with future treatement referred to above?	Yes	No
What are the pre-existing conditions?		
Have the injuries aggravated any pre-existing pathological condition?	Yes	No
If yes, please give details		
Have any such pre-existing pathological conditions aggravated the effects of trauma?	Yes	No
If yes, please give details		
Has the patient been confined to a hospital/rehab centre/ stepdown facility?	Yes	No
Date of admission		
Name and address and practice number of facility		
Hospital reference number		
Date of discharge or when discharge is expected		
If in employment at date of accident, state date when return to employment is expected		

12.2 Medical Report - Medical Practitioners Details	
Name and Surname	
Speciality	
Practice Number (HPCSA and/or BHF)	
Telephone Number	
E-mail Address	
Cell Phone Number	
Postal Address	
Physical Address	
Signature	Affix Stamp (If applicable)
Date	

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13. Declaration and Consent:

The consent granted to the RAF in this paragraph authorises the RAF to obtain copies of any records and to access any information which relates to this claim for compensation and to contact any person or entity for purposes of obtaining or verifying such information and /or documentation.

I, ____ (name and surname of claimant), declare that, to the best of my knowledge, the information provided in this Third Party Claim Form is true and correct in every respect; and

I confirm that I am claiming compensation:

In my personal capacity as a result of injuries I sustained in the accident; alternatively

In my personal and / or representative capacity as ____________________________

(state capacity) on behalf of _____________________________ (name and surname of injured) who sustained injuries in the accident; alternatively

In my personal and / or representative capacity as ____________________________ (state capacity)

of ____________________________________ (state name of the deceased) who died as a result of the injuries sustained in the accident.

(Indicate, and if applicable complete the applicable statement above)

I hereby consent to the release, to the RAF, of copies of all documentation and /or information, including, but not limited to, documentation and /or information of a medical or financial nature, in the possession of any person or entity, which documentation or information, in any way, relates to this claim for compensation arising from the motor vehicle accident detailed in the claim form.

I further consent to, and authorise, the RAF to contact any person or entity for purposes of obtaining or verifying such information and /or documentation.

____

Signature of the Claimant

____

Signature of the Witness