

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, certified 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

- 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 completed 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

**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, prescribed 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 acceptable 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.

RAF 1 FORM



Important information

- 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.
- 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.
- 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.
- 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.
- The form and relevant supporting documents can be sent to us via our regional offices or by registered mail.
- This form consists of three sections: Section A, B and C.
- 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			Date of Birth	
ID Number / Passport Number		* Attach a certified copy of ID or passport				
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		<input checked="" type="checkbox"/>	Email	SMS	Post	Tel /Cell
Home / Preferred Language of Communication						
Country of Residence						
Ethnicity / Race		Country of Birth				
Sex	<input checked="" type="checkbox"/>	Male		Female		
Marital Status						
Residential Country						

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			<input checked="" type="checkbox"/>	Email	SMS	Post Tel /Cell
Home / Preferred Language of Communication					Marital Status	
Ethnicity / Race					Country of Birth	
Residential Country						
Sex	<input checked="" type="checkbox"/>	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 / Passport Number		* Attach a certified copy of ID or passport		
Country of Birth						
Residential Country						
Sex	<input checked="" type="checkbox"/>	Male		Female		

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

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	<input checked="" type="checkbox"/>	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>
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		<i>* Attach SAPS Accident Report</i>			
Name of Investigating Officer		<i>* Attach a docket</i>			
Accident Report Number (AR Number)					
Case Reference Number (CR Number)					
Post-mortem Results Relating to the Deceased		<i>* Post mortem report (for death claims only)</i>			
Accident Notification - RAF 3 Form Reference Number					
<i>* Attach accident report or copy of the case docket or both documents in case of death</i>					
3.2 Injured/Deceased Capacity					
Capacity in Accident <input checked="" type="checkbox"/>		Pedestrian		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					

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	<small>*Attach certified copy of driver's licence</small>
Category of Licence and Restrictions	
Date of Issue	
Valid	From <input type="text"/> To <input type="text"/>
Insurance Details (Include All Details of Claim)	

3.5 Accident Scenarios of a Driver or Motorcyclist				
Head-on collision	<small>or not applicable</small>			
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	<small>All vehicles involved</small>			
Vehicle Make and Model				
Driver's Contact Details	<small>All vehicles involved</small>			
Unidentified Motor Vehicle	Yes		No	
Please indicate if any of the vehicles is a public transport vehicle				
3.7 Witnesses				
Any Witnesses to the Accident?	<small>If yes, attached the witness statement(s)</small>			
Witness's Name and Surname	Yes		No	
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	<small>If yes, attach results</small>		<small>Attach results</small>	
		Yes	No	

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	<small>*Attach final award</small>	Yes	No
5.2 Employment Status			
Status	<input checked="" type="checkbox"/>	Employed	Self-Employed Unemployed
Employment Sector Category	<small>or not applicable</small>		
	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)			

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	*				
<i>attach proof of items marked with an *</i>					
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					

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	

7. Medical Report										
<p><i>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.</i></p>										
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					<small>*Attach any clinical notes</small>					
Ward										
Step-down / Rehabilitation										

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			

Section C Death Benefit Claim			
8. Benefits Claimed			
Funeral Expenses	R	<input type="text"/>	*Specified Voucher (Tax invoice for funeral expenses)
Past Loss of Support	R	<input type="text"/>	*Proof of Income
Future Loss of Support	R	<input type="text"/>	*Proof of Income
Past Medical Expenses	R	<input type="text"/>	*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	<input type="text"/>		
Amount Received	<input type="text"/>		
9.2 Deceased Employment Status			
Status	<input checked="" type="checkbox"/>	Employed	Self-Employed
Employment Sector Category	<input checked="" type="checkbox"/> or not applicable		
Self-employed	<input type="text"/>		
Public Servant	<input type="text"/>		
Formal Regulated Industry	<input type="text"/>		
Informal Unregulated Industry	<input type="text"/>		
Employment Sector	<input type="text"/>		
Agriculture, Food and Natural Resources	<input type="text"/>		
Architecture and Construction	<input type="text"/>		
Arts, Audio/Video Technology and Communications	<input type="text"/>		
Business Management and Administration	<input type="text"/>		
Education and Training	<input type="text"/>		
Finance	<input type="text"/>		
Government and Public Administration	<input type="text"/>		
Health Science	<input type="text"/>		
Hospitality and Tourism	<input type="text"/>		
Human Services	<input type="text"/>		
Information Technology	<input type="text"/>		
Law, Public Safety, Corrections and Security	<input type="text"/>		
Manufacturing	<input type="text"/>		
Marketing, Sales and Service	<input type="text"/>		
Science, Technology, Engineering and Mathematics	<input type="text"/>		
Transportation, Distribution and Logistics	<input type="text"/>		
Other (Specify)	<input type="text"/>		

Final Award	<small>*Attach final award</small>			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	<input checked="" type="checkbox"/>	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	*				
<i>attach proof of items marked with an *</i>					
10.4 Self-Employed Deceased					
Business Name					
Nature of Business	<input checked="" type="checkbox"/>				
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 Remuneration					
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					

11.1 Substantial Compliance Death Claims	
Standard documents	✓ or not applicable
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	

12. Medical Report (Only Applicable Where the Deceased Did Not Die at the Scene)											
<p><i>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.</i></p>											
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											

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		
Is 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 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		
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		

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