

<b>ACCIDENT REPORT FORM (ARF)</b>					
<b>PERSONAL DETAILS OF THE PRINCIPAL MEMBER</b>					
MEDICAL SCHEME / FUND					
MEMBERSHIP NUMBER					
MEMBER FIRST NAME					
SURNAME					
IDENTITY NUMBER					
CONTACT NUMBER	CELL				
	WORK				
	HOME				
	FAX				
	ADDITIONAL				
EMAIL					
RESIDENTIAL ADDRESS					
POSTAL ADDRESS					
<b>DETAILS OF THE INCIDENT</b>					
DATE OF THE INCIDENT					
WHO WAS THE DRIVER					
PLACE OF THE ACCIDENT					
DESCRIPTION OF HOW THE ACCIDENT HAPPENED					
WHO IN YOUR OPINION WAS TO BLAME FOR THE ACCIDENT					
<b>INJURED PERSON'S DETAILS</b>					
FIRST NAME					
SURNAME					
IDENTITY NUMBER					
WAS THE INJURED	DRIVER		PASSENGER		PEDESTRIAN
CELL NUMBER					
WAS THE INJURED ON DUTY AT THE TIME OF THE ACCIDENT	YES	NO	YES	NO	
EMAIL					
DESCRIPTION OF INJURIES SUSTAINED					
HAVE YOU LODGED A CLAIM AGAINST RAF	YES	NO	YES	NO	
<b>THE INJURED PERSON'S DETAILS</b>					
FIRST NAME					
SURNAME					
IDENTITY NUMBER					

WAS THE INJURED	DRIVER		PASSENGER		PEDESTRIAN	
CELL NUMBER						
WAS THE INJURED ON DUTY AT THE TIME OF THE ACCIDENT	YES		NO		YES	NO
EMAIL						
DESCRIPTION OF INJURIES SUSTAINED						
HAVE YOU LODGED A CLAIM AGAINST RAF	YES		NO		YES	NO
<b>THE INJURED PERSON'S DETAILS</b>						
FIRST NAME						
SURNAME						
IDENTITY NUMBER						
WAS THE INJURED	DRIVER		PASSENGER		PEDESTRIAN	
CELL NUMBER						
WAS THE INJURED ON DUTY AT THE TIME OF THE ACCIDENT	YES		NO		YES	NO
EMAIL						
DESCRIPTION OF INJURIES SUSTAINED						
HAVE YOU LODGED A CLAIM AGAINST RAF	YES		NO		YES	NO
<b>THE INJURED PERSON'S DETAILS</b>						
FIRST NAME						
SURNAME						
IDENTITY NUMBER						
WAS THE INJURED	DRIVER		PASSENGER		PEDESTRIAN	
CELL NUMBER						
WAS THE INJURED ON DUTY AT THE TIME OF THE ACCIDENT	YES		NO		YES	NO
EMAIL						
DESCRIPTION OF INJURIES SUSTAINED						
HAVE YOU LODGED A CLAIM AGAINST RAF	YES		NO		YES	NO
<b>THE ATTORNEY'S DETAILS</b>						
HAVE YOU APPOINTED AN ATTORNEY	YES		NO		YES	NO
IF YES PLEASE PROVIDE US WITH THE ATTORNEY DETAILS						
NAME OF THE FIRM						
CONTACT PERSON						
FILE/ REFERENCE NUMBER						
DETAILS	TELEPHONE					
	EMAIL					
	FAX					

**THE MEMBER'S UNDERTAKING FOR THIRD PARTY CLAIM**

I, the undersigned, being the member, hereby undertake to:

1. On the finalization of a claim against the Road Accident Fund or party responsible for my/my dependant's injuries, ensure that all amounts recovered in respect of medical and hospital expenses incurred by the Medical Aid Scheme as at date of finalization of the said claim, will be paid to the Scheme or its authorized representative, within seven (7) days of receipt thereof by my legal representative.
2. Ensure that prior to the settlement of the claim; all amounts expended by the Medical Aid Scheme are included in such claim.
3. Disclose to the Medical Aid Scheme on request, the full extent of any compensation received in respect of past and future medical expenses on the finalization of the claim. Alternatively, I authorize the Medical Aid Scheme or its authorized representatives, to obtain any information from the Road Accident Fund and/or documentation as may be reasonably required by the Medical Aid Scheme, to ascertain the full extent of any compensation received.
4. Authorize and empower the Medical Aid Scheme and/or its duly appointed representative to obtain copies of all my/my dependant's accident related medical and hospital accounts from the relevant supplier.
5. Disclose to the Medical Aid Scheme at its request the progress being made with my/my dependant's claim for compensation.
6. On the merits of my/my dependant's matter having been finalized with the Road Accident Fund my attorney of record to apply to the Road Accident Fund or a court of law having competent jurisdiction for an interim payment in respect of the amount expended by the scheme for my/my dependant's accident related past hospital and future hospital medical expenses.
7. Effect payment of any amounts due to the Medical Aid Scheme as recovered by way of an interim payment received from the party liable to compensate me/my dependant within (7) days of receipt thereof by either myself, my dependant or my legal representative.
8. Advise the Scheme should my appointed Attorney's mandate be terminated.

**Full Name of Member** .....

**Member's Signature** .....

**Date** .....

**THE FOLLOWING SECTION IS TO BE SIGNED BY YOUR ATTORNEY ONCE APPOINTED**

I ..... practicing under the name ..... Attorneys being duly authorized to represent..... in a claim against the Road Accident Fund, do hereby confirm that I shall effect payment to the Scheme in terms of this undertaking and further confirm my instructions to adhere to the terms and conditions thereof.

**Attorney's Signature** .....

**Date** .....

**Attorney's reference number** .....