

THE MEMBER'S UNDERTAKING FOR THIRD PARTY CLAIM

ACCIDENT REPORT FORM (ARF)									
PERSONAL DETAILS OF THE PRINCIPAL MEMBER									
MEDICAL SCHEME / FUND									
MEMBERSHIP N	UMBER								
MEMBER FIRST	NAME								
SURNAME									
IDENTITY NUMB	ER								
CONTACT	CELL								
NUMBER	WORK								
	HOME								
	FAX								
	ADDITIONAL								
EMAIL									
RESIDENTIAL AD	DRESS								
POSTAL ADDRES	S								
		DETAILS	OF T	HE INCIDENT					
DATE OF THE IN									
WHO WAS THE I									
PLACE OF THE A									
DESCRIPTION OF HOW THE									
ACCIDENT HAPP									
WHO IN YOUR OPINION WAS TO									
BLAME FOR THE ACCIDENT									
		INJURED	PERS	ON'S DETAILS					
FIRST NAME									
SURNAME									
IDENTITY NUMBER									
WAS THE INJURI	ED	DRIVER		PASSENGER	3		PED	DESTRIAN	
CELL NUMBER									
WAS THE INJURED ON DUTY AT		YES		NO		YES		NO	
THE TIME OF THE ACCIDENT									
EMAIL									
DESCRIPTION OF INJURIES									
SUSTAINED									
HAVE YOU LODGED A CLAIM		YES		NO		YES		NO	
AGAINST RAF		. =0							
	THE INJURED PERSON'S DETAILS								
FIRST NAME									
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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 T	O BE SIGNED BY YOUR ATTORNEY ONCE APPOINTED	
I pı	acticing under the name Attorneys being duly au	ıthorized to
represent	in a claim against the Road Accident Fund, do her	eby confirm
that I shall effect payment to t	he Scheme in terms of this undertaking and further confirm my instructions t	o adhere to
the terms and conditions there	of.	
Attorney's Signature		
Date		
Attorney's reference number		