THE MEMBER'S UNDERTAKING FOR THIRD PARTY CLAIM

ACCIDENT REPORT FORM (ARF)			
PERSONAL DETAILS OF THE PRINCIPAL MEMBER			
MEDICAL SCHEME / FUND			
MEMBERSHIP NUMBER			
MEMBER FIRST NAME			
SURNAME			
IDENTITY NUMBER			
CONTACT NUMBER	CELL		
	WORK		
	HOME		
	FAX		
	ADDITIONAL		
EMAIL			
RESIDENTIAL ADDRESS			
POSTAL ADDRESS			

DETAILS OF THE INCIDENT							
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							
INJURED PERSON'S DETAILS							
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	
THE INJURED PERSON'S DETAILS							
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	
THE INJURED PERSON'S DETAILS							
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	
THE INJURED PERSON'S DETAILS							
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	
THE ATTORNEY'S DETAILS							
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						

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 …….

<u>THE FOLLOWING SECTION IS TO BE SIGNED BY YOUR ATTORNEY ONCE APPOINTED</u>

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 …….