THIRD PARTY CLAIM FORM

Road Accident Fund

RAF 1

1 PERSONAL DETAILS OF CLAIMANT:

Title: Mrs

Surname: Parker

Name: Sarah

Date of birth: 1978/04/10

ID number / Passport number

Note: A certified legible copy of your identity document must be attached to this claim form

Residential address: 50 Harper Road, Constantia

Postal address: Same as residential address

Home telephone number: 021 458 7891

Work telephone number:

Cellular number: 079529856

Email: sarahparker.gmail.com

How would you like us to contact you?

E-mail		SMS		Post	
Tel (H)		Tel (W)		Cell	X

2 DETAILS OF PERSON CLAIMING IN REPRESENTATIVE CAPACITY:

Are you claiming compensation on behalf of someone else?

X YES ☐ NO

If you answered YES kindly furnish the following information

Your name & surname: address: Same as above

Your ID / passport number:

In what capacity are you acting: Spouse (wife)

3 BANK ACCOUNT DETAILS OF CLAIMANT:

If your claim is successful the RAF will pay you directly. Please provide bank account details for payment of compensation due to you.

Bank (Name)

Account number:

Branch number

Name of account holder

4 BANK ACCOUNT DETAILS OF THE CLAIMANT'S LEGAL REPRESENTATIVE:

If costs become due, please provide details of the account into which you want the costs to be paid.

Account number	Bank name
4589520	Standard Bank
Branch code	Name of account holder
021	Malcolm Lyons and Brivik Inc

Kindly attach one of the following documents to the claim form to enable the RAF to verify the banking details: a cancelled cheque or a certified legible copy/original statement of account which clearly indicates the account holder's name, account and branch number, or an original letter from the bank (on an official letterhead) which confirms the account holder's name, account and branch number.

5 MOTOR VEHICLE ACCIDENT DETAILS:

Date of accident

2010/08/06 YY/MM/DD

Time of accident

18H00 HH/MM

Place of accident (street number and name, suburb, town, province)

Intersection of Kroboom road and Jan Smuts Drive

Address of SAPS station where the accident was reported

Jan Smuts Drive

Accident report number

97/08/2010

In the accident were you (or the injured / deceased)

Driver	X	complete paragraph 7
Motorcyclist		complete paragraph 7
Motorcycle passenger		complete paragraph 6
Passenger		complete paragraph 6
Cyclist		complete paragraph 6
Pedestrian		complete paragraph 6

In an affidavit, to be attached to this claim form, please describe how the accident occurred

6 PASSENGERS, PEDESTRIANS & CYCLISTS:

What is the registration number of the vehicle on or in which you / injured / deceased was a passenger?

CA 1245

What is the driver's name and surname?

Ben Parker

If you were a cyclist or a pedestrian, what is the registration number(s) of the other vechicle(s) involved in the accident?

Driver's physical address:

50 Harper Road
Constantia

Driver's contact number:

079529856

What is the driver's name and surname?

7 DRIVER / MOTOR CYCLIST:

What is the registration number of the motor vehicle / motorcycle driven by you (or the injured / deceased)?

CA 1245

If you (or the injured / deceased) are not the owner of the motor vehicle / motorcycle kindly furnish the following information in respect of the owner -

Name and surname

N/A

Telephone number:

N/A

Cell number:

N/A

Physical address:

N/A

8 DETAILS OF OTHER VEHICLES IN THE ACCIDENT:

Please provide details of any other vehicles involved in this accident. (Pedestrians and cyclists, must also answer this question by providing details of the vehicles involved.)

Registration number:	Driver's contact number:
CFM 258	0794530011

Registration number:	Driver's contact number:

Was this a "hit-and-run" accident?

[ ] Yes [X] No

9 PARTICULARS OF DECEASED (IF APPLICABLE):

Name

Ben

Surname

Parker

ID number

196012018002015

Date of birth

1960/01/20

Date of death

21/08/2010

What is your relationship to the deceased?

Husband

Kindly attach a copy of the death certificate, inquest report or charge sheet

10 SAFETY MEASURES:

Kindly indicate whether you (or the injured) were wearing a seatbelt at the time of the accident?

Yes [X] No [ ]

OR

Kindly indicate whether you (or the injured) were wearing a helmet at the time of the accident?

Yes [ ] No [ ]

11 DETAILS OF WORKMAN'S COMPENSATION:

The Compensation for Occupational Injuries and Diseases Act gives workers the right to claim compensation if they are injured during work.

Did the motor vehicle accident give rise to a claim(s) under the Compensation for Occupational Injuries and Diseases Act

Yes [ ] No [ ]

If you answered YES kindly furnish the following information. Did you lodge a claim with the Compensation Fund.

Yes [ ] No [ ]

If YES furnish the Compensation Fund's reference number

N/A

State the amount of compensation received to date

N/A

Indicate whether the compensation received represents the final award

Yes [ ] No [ ]

12 WITNESSES:

Were there any witness(es) to the accident?

Yes [X] No [ ]

If you answered YES kindly furnish the following information in respect of such witness(es):

Name and Surname

Mary Loubsher

Address

45 Wood Road
Rondebosch

Telephone no

021 689 4568

Cell no

084 456 1230

Name and Surname

Address

Telephone no

Cell no

(Should this claim form not provide enough space to list all the witnesses kindly list the remaining witnesses and their details on a separate page to be attached to this claim form)

13 EMPLOYMENT STATUS:

What was the injured's / deceased's employment status at the time of the accident?

Employed [X]

Self employed [ ]

Unemployed [ ]

14 EMPLOYED DETAILS:

Was the claimant or / the injured required to take time off work due to injuries sustained in the accident

Yes [ ] No [ ]

If you answered YES, please furnish the the following details

Dates not at work

YYYY/MM/DD YYYY/MM/DD

Number of work days the injured was not at work

Did the injured receive payment from the employer while not at work

Yes [ ] No [ ]

If you answered YES, please indicate the amount received

If you answered YES to the previous question, what was the nature of the payment received from the employer

[ ] sick leave [ ] gratuitous [ ] or other

If you answered OTHER, please indicate the nature of the payment

15 EMPLOYER'S DETAILS:

Please provide the following details regarding the injured's / deceased's employment.

Name of employer

Warren Smith (Allan Gray)

Postal address

40 Warf Road

Cape Town

Telephone number

021 4789 9630

Contact person

Barry Hilton

Employee number

N/A

Kindly indicate the basis of employment

[X] Permanent [ ] Temporary

[ ] Casual [ ] Contract

If the employment is (or was) on a temporary/ casual or contractual basis please indicate:

Date of commencement

N/AY/MM/DD

Date of expiry

YYYY/MM/DD

16 PROOF OF INCOME:

To assist the RAF with the processing of the claim, for past and / or future loss of income, please indicate the documents you can provide to confirm the injured's / deceased's earnings.

[ ] Payslips

[ ] Most recent tax return

[X] Printout of payments from employer

[ ] PayslipsBank Statements

[ ] Other. Please specify:

[ ] Printout of payments from employer

(Kindly attach copies of the documents identified by you to this claim form).

Tax reference Number

789620

17 SELF EMPLOYED CLAIMANTS:

If the injured / deceased was self employed please complete the following details:

Business name

Nature of business

Business address

Identify the applicable legal entity in respect of the injured / deceased business-

If applicable, kindly furnish the Company / Close Corporation / Trust registration number of the business

Has the injured / deceased / business lodged tax returns during last 3 financial years

☐ Yes ☐ No

If you answered YES, please attach copies of those tax returns to this claim form

If you answered NO, please attach income and expenditure statements / bank statements for the business, for the past 3 years or for such shorter period that the injured / deceased has been in business.

☐ sole trader ☐ partnership ☐ trust ☐ close corporation ☐ company

☐ other - specify

18 CLAIMS FOR LOSS OF SUPPORT:

Please furnish the requested details of all the persons who, at the time of death, were dependent on the deceased for support

Dependant 1

Name	Mark Parker
Date of birth	1999/11/11
ID number	9911111280080
Relationship	son
Reason for dependence	minor

Dependant 2

Name	Sarah Parker
Date of birth	1978/04/10
ID number	7804101280080
Relationship	Spouse
Reason for dependence	Housewife

Dependant 3

Name	
Date of birth	YYYY/MM/DD
ID number	
Relationship	
Reason for dependence	

Dependant 4

Name	
Date of birth	YYYY/MM/DD
ID number	
Relationship	
Reason for dependence	

Dependant 5

Name	
Date of birth	YYYY/MM/DD
ID number	
Relationship	
Reason for dependence	

Note: As proof of the relationship between the deceased and the particular dependent please attach certified copies of the relevant documentation, i.e. marriage certificate, unabridged birth certificate, adoption court order, etc.

(Should this claim form not provide enough space to list all the dependants kindly list the remaining dependants on a separate page to be attached to this claim form)

19 COMPENSATION CLAIMED:

Kindly indicate with an "X", in the space provided, the type(s) of compensation claimed as well as the exact amount claimed in respect of each type

	Type(s) of Compensation Claimed		
X	Emergency medical treatment	R	R 15 000
	Non-emergency medical treatment	R	
	Future medical expenses	R	
	Past loss of income	R	
	Future loss of income	R	
	Past loss of support	R	
	Future loss of support	R	
X	Funeral expenses (attach specified invoices)		R 10 000
	Non- pecuniary loss (general damages)*		
	Total Amount claimed	R	R 25 000

* If this claim includes a claim for non-pecuniary loss (general damages) please furnish the RAF with a serious injury assessment report as prescribed in the regulations.

20 SUBSTANTIAL COMPLIANCE:

Please complete the following information to validate your claim for substantial compliance with Section 24 of the RAF Act.

1. The identity (of the injured.) - (paragraph 1).
2. The date and place of accident (paragraph 5)
3. Identify the insured motor vehicles (paragraph 6 / 7 and 8).
4. A completed statutory medical report (paragraph 22);
5. Amount claimed as compensation (paragraph 19);
6. Attach accounts, vouchers, invoices etc. to support your claim for medical expenses;
7. Complete this form as prescribed in Section 24 of the RAF Act.
8. In the event that loss of support or funeral expenses are claimed provide documentary proof of the death of the deceased; and
9. Should the space provided in this claim form be insufficient to answer any question you are welcome to attach a further page to this claim form in which such further information can be provided to the RAF.
10. Should you require any assistance with the completion of this claim form please feel free to contact the RAF on ShareCall number 0860 2355 23.

21 DECLARATION AND CONSENT:

The Consent granted to the Road Accident Fund (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, Sarah Parker (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 Spouse and mother (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 Road Accident Fund, 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 Road Accident Fund 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

22 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

1. DETAILS OF PATIENT

Name	Surname
Ben	Parker
ID number	**Date of birth**
6001208002015	1960/01/20

2. PAST EMERGENCY MEDICAL TREATMENT

Note that, in terms of the regulations, emergency medical treatment is defined as "…the immediate, appropriate and justifiable medical evaluation, treatment and care required in an emergency situation in order to preserve the person's life or bodily functions, or both"

Did the patient receive emergency medical treatment, as defined

[X] Yes [ ] No

If you answered YES, please furnish the following information in respect of such treatment –

What was the nature of the treatment?

[X] Emergency transport

[X] Hospital care

[ ] ICU

[ ] Other, if other please indicate nature of the treatment

ICD 10 Code	Treatment plan

Kindly furnish the ICD 10 codes applicable to the emergency medical treatment provided to the patient and motivate why the treatment is viewed as emergency medical treatment. Should the space provided in this claim form be insufficient to answer any question attach a further page(es) to this claim form in which such further information can be provided to the RAF.

MEDICAL REPORT:

3. PAST NON-EMERGENCY MEDICAL TREATMENT

Note that all medical evaluations and treatment that fall outside the prescribed definition of emergency medical treatment, is non-emergency medical treatment.

Did the patient receive non-emergency medical treatment?

[ ] Yes [X] No

If you answered YES, please furnish the following information in respect of such treatment.
In the schedule below, kindly identify the specific ICD 10 code(s) applicable and describe the treatment administered

ICD 10 Code	Treatment plan

4. PRE-EXISTING MEDICAL CONDITIONS

Did the patient suffer from any pre-existing condition(s) (injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment).

[ ] Yes [X] No

If you answered YES, please identify the pre-existing condition(s), furnish the applicable ICD 10 code(s) (if such a code exists) and describe the impact of the injury(ies) sustained in the accident on such pre-existing condition(s)

Pre-existing condition	ICD 10 Code	Impact of accident
N/A		

MEDICAL REPORT:

5. FUTURE MEDICAL TREATMENT

Is the patient currently receiving ongoing medical treatment for the injury(ies) sustained in the accident, or is it foreseen that the patient would require future medical treatment for such injury(ies)

[ ] Yes [X] No

If you answered YES, please furnish the name(s) and contact number(s) of the service provider(s) who will be rendering treatment, future treatment.

6. MEDICAL TREATMENT IN MEDICAL FACILITY/HOSPITAL

Was the patient admitted to a medical facility / hospital as a result of the injury(ies) sustained in the accident, or did he patient receive treatment at a medical facility / hospital for such injury(ies)

[X] Yes [ ] No

If you answered YES, please furnish the name(s) and contact number(s) of the hospital / facility, and if admitted, the date admitted and date discharged

Name of Hospital / Facility	Contact number	Date admitted	Date discharged
Medi Clinic	021 852 1590	2010/08/06	(died)
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD

7. MEDICAL PRACTITIONERS DETAILS

Name: Louis

Surname: Walsh

Qualifications: MBCHB

Practice Number (HPCSA and/or BHF):

Telephone number: 021 852 1590

Facsimile number:

Cell number: 084 9630 741

Postal address:

Physical address: 45 Jupiter Street
Surrey Estate

DECLARATION:

DECLARATION

I hereby declare that to the best of my knowledge and belief the information set out in this medical report is true and correct in every respect.

Signature of medical practitioner	
	OFFICIAL STAMP
Signed at	
Date	YYYY/MM/DD