



MOTOR VEHICLE ACCIDENT FUND

MEDICAL FORM

SECTION 1

1.1: PATIENT'S PARTICULARS

Name _____ Surname _____
Sex _____ Age _____ Next of Kin _____
Medical Aid _____
Occupation _____
Postal Address _____
Physical Address _____
Telephone _____ (H) _____ (W) E-mail _____

1.2: NEXT OF KIN PARTICULARS (as above)

Name _____ Surname _____
Sex _____ Age _____ Next of Kin _____
Medical Aid _____
Occupation _____
Postal Address _____
Physical Address _____
Telephone _____ (H) _____ (W) E-mail _____

SECTION 5: DETAILS OF REPORTING MEDICAL DOCTOR

5.1: Particulars

Name _____ Surname _____

Name of Hospital/Clinic _____

Address _____

Telephone _____ Fax _____

Email _____

Signature _____ Date _____

Official Stamp _____

5.2: DETAILS OF CLAIM

Invoice # _____

Amount Claimed _____

N:B ATTACH THE ORIGINAL INVOICE

A handwritten signature in black ink, appearing to read "Stumr".

