FORM 2

CLAIM BY SUPPLIER

(Sections 17(5) and 24(3) of Act No. 56 of 1996 and regulation 3(2) of the Regulations under the Act.)

Notes:

(i) A separate form must be completed and lodged in respect of each injured or deceased person who was accommodated in a hospital or nursing home, or was treated, or to whom any service was rendered or goods supplied.
(ii) This form must be completed in all its particulars. A clear reply must be given to each question, and if a question is not applicable the words "not applicable" must be inserted. A form on which ticks, dashes, deletions and alterations have been made that are not confirmed by a signature, will not be regarded as properly completed.
(iii) This claim must be sent by registered post or delivered by hand to the Fund.
(iv) Where blocks are provided for the purpose of replying to a question, place a cross in the appropriate block.

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1. Claimant (medical or dental practitioner/nurse/supplier/pharmacist/hospital/nursing home):
   (a) Full name..... .....
   (b) Registered qualifications .....
   (c) Address..... .....
   .....
2. Injured or deceased person:
   (a) Full name..... .....
   (b) (i) Registration letters and numbers of motor vehicle from the driving of which this claim arises:.....
   (ii) Name and address of owner at time of accident..... .....
   .....
   (iii) Name and address of driver at time of accident..... .....
   .....
   (c) Accident: (i) Date..... (ii) Time.....
   (iii) Place.....
   (d) Nature of injuries..... .....
   .....
   (e) Names of hospitals/institutions in which he/she was treated or is being treated.....
   .....
   (f) Classification for hospital purposes:

   Private patient ☐ Hospital patient ☐
   (g) Hospital reference number..... .....
3. Treatment/services rendered/goods supplied:
   (a) Dates/duration of treatment/services rendered/goods supplied:
   From..... to..... .....
   ....
   (b) Nature/details of treatment/services rendered/goods supplied (specify each item):
   ..... R.....
   ..... R.....
   ..... R.....
   ..... R.....
   ..... R.....
   Total..... R.....
4. Accommodation in hospital/nursing home:
   (a) Period of accommodation:
   from.....to.....
   (b) Number of days.....at.....per day R..... .....
   (c) Out-patient treatment-

	Number.....at R.....each.....	R..... .....
(d)	Operating theatre fee.....	R..... .....
(e)	Other (specify).....	R..... .....
	.....	R.....
	.....	R.....
	.....	R.....
	Total.....	R.....

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Signature *Date*