RAF 1 FORM

Important information

a. This is a Form to be completed for claims for compensation under section 17 of the Road Accident Fund Act as prescribed in section 24(1)(a) and regulation 7.
b. This Form must be completed in its full particulars and in instances where there are asterisks indicating that supporting documents will be required, such must be included for completeness.
c. Your attention is drawn to the provision of section 24(4)(a) that any Form that is not completed in its full particulars shall not be acceptable as a claim.
d. Consequently, your submitted Form would not interrupt prescription as provided for in section 23 of the Act
e. The RAF reserves the right not to accept an incomplete Form.
f. The Form and relevant supporting documents can be sent to us by registered mail or delivered by hand to any of our regional offices
g. This Form consists of three sections, Section A, B and C.
h. Complete Section A and B if claiming for Injury benefits and section A and C for death benefits.

Section A

1. Capacity

Unrepresented	
Represented **Attach power of attorney*	

1.1 Details of Legal Representative

Representative Name & Surname	
Name of Firm	

1.2 Bank Account Details of Claimant / Legal Representative

Bank Name	
Branch Number	
Account Number	
Name of Account Holder	

2. Personal Information

2.1 Personal Details of the Claimant

Title		**Date of Birth**	
Name and Surname			
ID Number / Passport Number			
Residential Address	Complex		
	Street		
	Town		
	Province		
	Postal Code		
Postal Address	Complex		
	Street		
	Town		
	Province		
	Postal Code		
Home Telephone Number		**Work Telephone Number**	
Cellular Number		**Email**	

Preferred method of communication	✓	Email	SMS	Post	Tel /Cell
Home / Preferred Language of Communication					

Ethnicity / Race		**Country of Birth**	
Country of Residence			
Relationship to the Injured /Deceased			

Sex	✓	Male		Female	

2.2 Personal Details of the Injured (complete only if the claimant is not the injured)							
Title		**Name and Surname**					
Date of Birth		**ID Number / Passport Number**					** Attach a certified copy of ID, unabridged birth certificate or passport*
Residential Address		Complex					
		Street					
		Town					
		Province					
		Postal Code					
Postal Address		Complex					
		Street					
		Town					
		Province					
		Postal Code					
Home Telephone Number			**Work Telephone Number**				
Cellular Number			**Email**				
Preferred method of communication		✓	Email	SMS	Post	Tel /Cell	
Home / Preferred Language of Communication			**Marital Status**				
Ethnicity / Race			**Country of Birth**				
Country of Residence							
Sex	✓	Male		Female			

2.3 Personal Details of the Deceased				
Title		**Name and Surname**		
Date of Birth		**Date of Death**		** Attach a certified copy of death certificate*
Residential Address		Complex		
		Street		
		Town		
		Province		
		Postal Code		
Time of Death		**ID Number /**		** Attach a certified copy of ID or passport*
		Passport Number		
Country of Birth				
Country of Residence				
Sex	✓	Male	Female	

2.4 Personal Details of Dependants No:1	
Title	
Name and Surname	
Date of Birth	
ID Number / Passport Number	*certified marriage certificate/ unabridged birth certificate/Affidavit confirming relationship
Ethnicity / Race	
Country of Birth	
Country of Residence	
Sex (Male/Female)	
Relationship to the Deceased	
Reason for dependence	
Marital Status	

2.4 Personal Details of Dependants No:2	
Title	
Name and Surname	
Date of Birth	
ID Number / Passport Number	*certified marriage certificate/ unabridged birth certificate/Affidavit confirming relationship
Ethnicity / Race	
Country of Birth	
Country of Residence	
Sex (Male/Female)	
Relationship to the Deceased	
Reason for dependence	
Marital Status	

2.4 Personal Details of Dependants No:3	
Title	
Name and Surname	
Date of Birth	
ID Number / Passport Number	*certified marriage certificate/ unabridged birth certificate/Affidavit confirming relationship
Ethnicity / Race	
Country of Birth	
Country of Residence	
Sex (Male/Female)	
Relationship to the Deceased	
Reason for dependence	
Marital Status	

2.4 Personal Details of Dependants No:4	
Title	
Name and Surname	
Date of Birth	
ID Number / Passport Number	*certified marriage certificate/ unabridged birth certificate/Affidavit confirming relationship
Ethnicity / Race	
Country of Birth	
Country of Residence	
Sex (Male/Female)	
Relationship to the Deceased	
Reason for dependence	
Marital Status	

Complete additional pages in case of more than four dependants

2.5 Next of Kin Details					
Title	**Name and Surname**				
Home Telephone Number		**Work Telephone Number**			
Cellular Number		**Email**			
Relationship to Claimant/Injured					

3. Accident Details

3.1 Motor Vehicle Accident Details

Date of Accident		
Time of Accident		
Place of accident	Street	
	Town	
	Province	
	Postal Code	
Name and Address of Police Station were the accident was reported	Name	
	Town	
	Province	
	Postal Code	
Contact details of SAPS station		** Attach SAPS Accident Report*
Name of investigating officer		** Attach a docket*
Accident Report Number (AR number)		
Case Number (CR number)		
Post mortem results relating to the deceased		** Post-mortem report/ Inquest record/ charge sheet/other documents proving that the deceased was killed in the accident*

3.2 Injured/Deceased Capacity

Capacity in Accident ✓	Driver	Motorcyclist	Passenger	Cyclist	Pedestrian	
Vehicle Registration Number						
Driver Name & Surname						
Vehicle Make and Model						
Please indicate if the vehicle claimed against is a public transport vehicle ✓			**Yes**		**No**	
Driver Physical Address	Complex					
	Street					
	Town					
	Province					
	Postal Code					
Driver cell phone number						

To be completed where the injured or deceased was a pedestrian or cyclist

3.3 Accident Scenarios of Pedestrians & Cyclists Details	✓
Crossing a road with poor visibility & unobstructed view of oncoming traffic	
Crossing the road at a robot controlled intersection/pedestrian crossing/robot controlled pedestrian crossing	
Crossing in front or behind a stationary vehicle	
Crossing a highway	
Running/Cycling across the road	
Pedestrian standing on the centre line/painted island/centre island	
Was the injured pedestrian or cyclist under 7 year at the time of accident?	
Was the injured pedestrian or cyclist between 7 and 14 years at the time of accident?	

To be completed where the injured or deceased was a driver or motorcyclist

3.4 Driver / Motorcyclist				
Vehicle Registration Number				
Vehicle type				
Vehicle Owner Name & Surname				
Vehicle Owner Telephone Number				
Vehicle Owner Cell Number				
Vehicle Owner Physical Address	Complex			
	Street			
	Town			
	Province			
	Postal Code			
Drivers Licence number				
Category of licence and restrictions				
Date of issue				
Valid	From		To	
Insurance details (Include all details of claim)				

3.5 Accident scenarios of a Driver	✓ or not applicable	
Head on collision	Yes	No
Rear end collision	Yes	No
Stop street controlled intersection (4 way, T junction, opposing stop streets)	Yes	No
Robot controlled intersection	Yes	No
Tyre burst	Yes	No
Collision with animal	Yes	No
Single vehicle accident	Yes	No
Accident with object	Yes	No
Poor visibility/dust cloud/smoke	Yes	No
Right turn	Yes	No
Overtaking	Yes	No
Lane change	Yes	No
T junction	Yes	No
Merging/ joining/yield sign	Yes	No
Traffic circle	Yes	No
Stationary vehicle	Yes	No
Reversing	Yes	No

3.6 Details of other vehicle(s) involved in the accident				
Vehicle Registration Number				*All vehicles involved*
Vehicle make and model				
Driver Contact Details				*All vehicles involved*
Unidentified Motor Vehicle	Yes		No	
Complete additional pages in case of more than one vehicle				

3.7 Witnesses				
Any Witnesses to the Accident?	Yes		No	
Witness Name and Surname				
Witness Address				
Witness Telephone Number				
Witness Cell Number				
Complete additional pages in case of more than one witness				

3.8 Safety Measures				
Was the seatbelt worn at time of accident or helmet?	Yes		No	
Blood alcohol tested	Yes		No	
Results	*If Yes Attach results*		Yes	No

Section B
Injury Benefits

4. Benefits Claimed

Past loss of earnings	R _____
Future loss of earnings	R _____
General Damages	R _____
Past Medical Expenses	R _____
Future Medical Expenses	R _____

5. Employment Information

5.1 Compensation for Occupational Injuries and Disease Act, 1993 (If applicable)

MVA under Compensation for Occupational Injuries and Diseases Act, 1993	Yes	No
Claim Lodged with the Compensation Fund?	Yes	No
Compensation Fund Reference Number		
Amount Received		
Final Award **Attach final award*	Yes	No

5.2 Employment Status

Status	✓	Employed	Self-Employed	Unemployed

Employment Sector Category	✓ *or not applicable*
Self-employed	
Public Servant	
Formal Regulated Industry	
Informal Unregulated Industry	

Employment Sector	
Agriculture, Food and Natural Resources	
Architecture and Construction	
Arts, Audio/Video Technology and Communications	
Business Management and Administration	
Education and Training	
Finance	
Government and Public Administration	
Health Science	
Hospitality and Tourism	
Human Services	
Information Technology	
Law, Public Safety, Corrections and Security	
Manufacturing	
Marketing, Sales and Service	
Science, Technology, Engineering and Mathematics	
Transportation, Distribution and Logistics	
Other (specify)	

5.3 Employed Details				
Occupation				
Annual Remuneration (pre accident)				
Annual Remuneration (post accident)				
Highest Qualification and NQF Level				
Was the injured required to take time of duty?				
If yes , please specify the dates				
Number of work days absent				
Did you receive any remuneration while away from work?				
State amount received				
Nature of Payment Received ✓	Employment Contract		Ex-gratia	

5.4 Employer's Details			
Name of Employer			
Postal Address			
Telephone Number			
Contact Person			
Employee Number			
Basis of Employment ✓	Permanent	Temporary	Casual / Contract
Period of Temporary / Contract / Casual Employment			

5.5 Proof of Income					
Payslips		Tax Return		Declaration to give RAF consent to validate any income	Agree ✓
Printout of Payments from Employer		Bank Statements			
Other (Specify)					
Tax Reference Number					

5.6 Self Employed				
Business Name				
Nature of Business				
Business Address				
Type of Business Entity	✓	Sole Trader	Partnership	Trust
		Company	Close Corporation	Other

5.7 Minor's Injury Claims (as applicable)		
Level of education at the time of accident		
Age at the time of accident		
Level of education at the time of submitting the claim		
Age at the time of submitting claim		
School /university report pre - accident	*minimum 3 years' report	
School /university report post - accident		

6. Injury Details	
Type(s) of Injuries	
Severity of Injuries	
List of Injuries	
Hospital	
Address of Hospital	
Person who treated the deceased	

6.1 Substantial Compliance Injury Claims	✓ or not applicable
Standard documents	
Statutory Medical Report	
Amount Claimed as Compensation	
Certified copy of Claimant's ID (If claimant is a foreigner, proof of identity must be accompanied by documentary proof that the claimant was legally in South Africa at the time of the accident)	
Certified copy of Injured Identity Document (if different from Claimant) (If claimant is a foreigner, proof of identity must be accompanied by documentary proof that the claimant was legally in South Africa at the time of the accident)	
Unabridged birth certificate (if a natural guardian is claiming on behalf of a minor). If it's the legal guardian claiming on behalf of minor they must submit a court order or certified copies of Masters Letters of appointment	
Officers Accident Report or Case Docket and Sketch Plan	
Permission for the Fund to obtain and inspect hospital and medical records in terms of s19 (e)(ii) and 19 (e)(iii)	
Consent for RAF to obtain and inspect financial and earnings information	
Power of Attorney (if Represented)	
Affidavit in terms of Section 19 (f) (i)	
All statements and documents in claimant's possesion as outlined in s19 (f)(ii)	
Loss of Earnings	
Copies of all medical and hospital records, including photographs of the injuries	
Employer's certificate showing nature of employment, the period of service, remuneration, prospects of advancement and retirement age	
Proof of any other income (If applicable)	
Claimant's income tax returns submitted to SARS for the period during which the claimant was required to submit income tax returns, limited to the most recent three tax years, as applicable. (If not applicable, communication from SARS that the claimant is / was not registered as a taxpayer with SARS, in which case bank statements for the most recent three years preceding the date of accident will be required, as applicable.)	
Payslips pre and post-accident	
Copies of all hospital and medical accounts	
Medical reports or documentation establishing or substantiating claimant's temporary/ permanent disability and the loss of earnings claimed	
Official confirmation of remuneration / compensation received from other sources	
Official documentation confirming any disability grant	
Official confirmation of the Compensation Fund's award (if claimant was injured during the course and scope of employment)	
Past Medical Expenses	
An itemised tax invoice from a registered medical provider/or hospital for past medical expenses	
Proof of payment of medical expenses	
Copies of all medical and hospital records	

7. 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 or by the superintendent (or his representative) of the hospital in which the injured or deceased person was treated for such bodily injuries.

Patient Name and Surname	
Patient ID Number	
Patient Date of Birth	
Have you verified that this is the person mention in the injured section of the claim form using ID or Passport	
Date when first seen after the accident	
Did you treat the patient any time before?	
If yes, give date of last such treatment and nature of correct ailment	
Give full details of the nature of the injuries and any complications (e.g. fractured rib with haemothorax, contusion of the heart, compound fracture etc.)	

Parts of the body injured and degree

	Head	CNS	Chest	Neck	Abdomen	Back	Upper Limbs	Lower Limbs	Pelvis	Musculo-skeletal & skin
Minor										
Moderate										
Severe										

ICD 10 CODE	PROCEDURE	TREATMENT PLAN

8. Level of care and duration

Level of care	Duration
ICU	
High Care	**Attach any clinical notes*
Ward	
Step-down / Rehabilitation	

Medical report continued		
Any other treatment give to date		
If no, has the condition stabilised		
Is there any future/ongoing medical treatment e.g. specialist, physiotherapy etc.?	Yes	No
If yes, provide name and address of treating service provider		
Any other treatment give to date?		
Is there any current or future permanent disability?	Yes	No
If yes, provide details		
If no, has the condition stabilised		
Is there any future/ongoing medical treatment e.g. specialist, physiotherapy etc.?	Yes	No
If yes, provide name and address of treating service provider		
What is the nature of such treatment?		
Is hospitalisation foreseen in connection with future treatment referred to above?	Yes	No
What are the pre-existing conditions?		
Have the injuries aggravated any pre-existing pathological condition?	Yes	No
If yes, please give details		
Has any such pre-existing pathological conditions aggravated the effects of trauma?	Yes	No
If yes, please give details		
Has the patient been confined to a hospital/rehab centre/ stepdown facility?	Yes	No
Date of admission		
Name and address and practice number of facility		
Hospital reference number		
Date of discharge or when discharge is expected		
If in employment at date of accident, state date when return to employment is expected		
9. Medical Report - Medical Practitioner's Details		
Name and Surname		
Speciality		
Practice Number (HPCSA and/or BHF)		
Telephone Number		
E-mail Address		
Cell Number		
Postal Address		
Physical Address		

Section C
Death Benefits

✓

9.1 Benefits claimed		
Funeral Expenses	R _____	*Specified Voucher (Tax invoice for funeral expenses) *Proof of Income *Specified vouchers and proof of payment
Past Loss of Support	R _____	
Future Loss of Support	R _____	
Past Medical Expenses	R _____	

10. Employment Details

10.1 Details of Workman's Compensation (If applicable)

MVA under Compensation for Occupational Injuries and Diseases Act	Yes	No
Claim Lodged with the Compensation Fund?	Yes	No
Compensation Fund Reference Number		
Amount Received		
Final Award **Attach final award*	Yes	No

10.2 Deceased Employment Status

Status	✓	Employed	Self-Employed	Unemployed

Employment Sector Category	✓ *or not applicable*
Self-employed	
Public Servant	
Formal Regulated Industry	
Informal Unregulated Industry	

Employment Sector	
Agriculture, Food and Natural Resources	
Architecture and Construction	
Arts, Audio/Video Technology and Communications	
Business Management and Administration	
Education and Training	
Finance	
Government and Public Administration	
Health Science	
Hospitality and Tourism	
Human Services	
Information Technology	
Law, Public Safety, Corrections and Security	
Manufacturing	
Marketing, Sales and Service	
Science, Technology, Engineering and Mathematics	
Transportation, Distribution and Logistics	
Other (specify)	

Final Award	YES	NO

11. Deceased's Employment Details

11.1 Deceased Employment Details

Annual Remuneration (Pre Accident)	
Annual Remuneration (Post Accident)	
Highest Qualification and NQF Level	

11.2 Deceased Employer's Details

Name of Employer				
Postal Address				
Telephone Number				
Contact Person				
Employee Number				
Basis of Employment	✓	Permanent	Temporary	Casual / Contract
Period of Temporary / Contract / Casual Employment				

11.3 Deceased Proof of Income

Payslips		**Tax Return**		**Declaration to give RAF consent to validate any income** **Agree** ✓
Printout of Payments from Employer		**Bank Statements**		
Other (Specify)				
Tax Reference Number				

11.4 Self Employed Deceased

Business Name			
Nature of Business			
Business Address			
Legal Entity of Business	Sole Trader	Partnership	Trust
	Company	Close Corporation	Other

11.5 Employment Details of the Surviving Spouse

Occupation	
Employer	
Annual Renumeration	
Payslip	
Tax Reference Number	
Declaration to give RAF consent to validate any income **Agree** ✓	

12. Injury Details (Only where the deceased did not die at the scene of the accident)

Type(s) of Injuries	
Severity of Injuries	
List of Injuries	
Hospital	
Address of Hospital	
Person who treated the deceased	

12.1 Substantial Compliance Death Claims	✓ or not applicable
Standard documents	
Completed Statutory Medical Report (Only applicable if the deceased did not die at the scene)	
Hospital and medical records (Only applicable if the deceased did not die at the scene)	
Amount Claimed as Compensation	
Certified copy of Claimant's ID (If claimant is a foreigner, proof of identity must be accompanied by documentary proof that the claimant was legally in South Africa at the time of the accident)	
Certified copy of Dependants ID	
Certified copy of Deceased ID	
Certified copy of Death Certificate	
Unabridged birth certificate (if a natural guardian is claiming on behalf of a minor). If it's the legal guardian claiming on behalf of minor they must submit a court order	
Officers Accident Report or Docket and Sketch Plan	
Consent for RAF to obtain and inspect hospital and medical records in terms of section 19 (e)(ii) and 19 (e)(iii)	
Court Order or Masters' letter of appointment (If Curator submitting on behalf of minor – LoS (Loss of Support) (If applicable) or certified copies of Masters Letters of appointment	
Power of Attorney (if Represented)	
Affidavit in terms of Section 19 (f) (i)	
Any other statements/documents in accordance with section 19 (f) (ii)	
Post Mortem/ Inquest Report/Charge sheet and/or any other document(s) proving that the deceased was killed in the collision or as a result of the collision	
Funeral	
Specified Voucher (Tax invoice for funeral expenses)	
Proof of Payment of funeral expenses	
Proof of relationship to deceased (certified marriage certificate/unabridged birth certificate/affidavit confirming relationship)	
Loss of Support	
Certified copy of marriage certificate/Certificate proving customary marriage/un-abridged birth certificate	
If not married, an affidavit setting out the legal basis of claimant's dependency on deceased	
Employer's certificate of deceased's service showing nature of employment, the period of service, remuneration, prospects of advancement and compensation and retirement age	
Payslips	
Copy of maintenance order, if any	
The child support grant official documents (if appicable)	
Deceased tax records (if not available, communication from SARS that Claimant is not registered for tax, in which case a bank statement for three years preceding death must be submitted)	
Offical proof of additional income (if applicable)	
Copy of Liquidation and Distribution account (if applicable)	
Employer's certificate of surviving spouse indicating period of employment, remuneration, prospects of advancement	
Proof of Guardianship (if claimant not biological parent)	
Academic records in respect of minor dependents	
Actuarial report	
Post Mortem Report/Inquest record/change sheet/ other documents proving that the deceased was killed in the accident	
Deceased's medical and hospital records (if applicable)	
Official confirmation of the Compensation Fund's award if the deceased died in the course and scope of employment	
Past Medical Expenses	
An itemised tax invoice from a registered medical provider/or hospital for past medical expenses with proof of payment	

13. Medical Report (only applicable where the Deceased did not die at the scene)

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 or by the superintendent (or his representative) of this hospital in which the injured or deceased person was treated for such bodily injuries.

Patient Name and Surname	
Patient ID Number	
Patient Date of Birth	
Have you verified that this is the person mention in the injured section of the claim form using ID or Passport	
Date when first seen after the accident	
Did you treat the patient any time before?	
If yes, give date of last such treatment and nature of correct ailment	
Give full details of the nature of the injuries and any complications (e.g. fractured rib with haemothorax, contusion of the heart, compound fracture etc.)	

Parts of body injured and degree

	Head	CNS	Chest	Neck	Abdomen	Back	Upper Limbs	Lower Limbs	Pelvis	Musculo-skeletal & skin
Minor										
Moderate										
Severe										

ICD 10 CODE	PROCEDURE	TREATMENT PLAN

13.1 Level of care and duration

Level of care	Duration
ICU	
High Care	**Attach any clinical notes*
Ward	
Step-down / Rehabilitation	
Ward	

Medical Report continued		
Any other treatment given to date		
If no, has the condition stabilised?	Yes	No
Is there any future/ongoing medical treatment e.g. specialist, physiotherapy etc.?	Yes	No
If yes, provide name and address of treating service provider		
Any other treatment give to date?		
Is there any current or future permanent disability?	Yes	No
If yes, provide details		
If no, has the condition stabilised?		
Is there any future/ongoing medical treatment e.g. specialist, physiotherapy etc.?		
If yes, provide name and address of treating service provider		
What is the nature of such treatment?		
Is hospitalisation foreseen in connection with future treatement reffered to above?	Yes	No
What are the pre-existing conditions?		
Have the injuries aggravated any pre-existing pathological condition?	Yes	No
If yes, please give details		
Has any such pre-existing pathological conditions aggravated the effects of trauma?	Yes	No
If yes, please give details		
Has the patient been confined to a hospital/rehab centre/ stepdown facility?	Yes	No
Date of admission		
Name and address and practice number of Facility		
Hospital reference number		
Date of discharge or when discharge is expected		
If in employment at date of accident, state date when return to employment is expected		

13.2 Medical Report - Medical Practitioners Details	
Name and Surname	
Speciality	
Practice Number (HPCSA and/or BHF)	
Telephone Number	
E-mail address	
Cell Number	
Postal Address	
Physical Address	

14. Mandatory information / documentation to be submitted for claims payments

To ensure that payments are processed in line with the settlement agreements concluded and / in compliance with court orders, the following documents must accompany any requests for payment:

1. Stamped Court Order / duly signed discharge form or settlement agreement.
2. Duly signed Power of Attorney.
3. Tax clearance certificate, which shall be submitted by the claimants' attorneys at least once a year.
4. Proof of banking details / confirmation of Banking Details (Trust Account).
5. Copy of the Contingency Fee Agreement concluded with the claimant and Proof of Compliance with section 4 of the Contingency Fee Act, altenatively, the attorney must submit an affidavit to confirm that there is no contigency fee agreement.

15. 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, _____ (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 _____ (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