FORM 'A'
MOTOR VEHICLE ACCIDENTS ACT, 1991
(ACT No. 13 OF 1991)

Claim for Compensation and Medical Report in terms of sections 10 and 16 of Act No 13 of 1991

(i) A Separate form must be completed and lodged with the MVA Fund in respect of each person or deceased person for whose injury or death compensation is claimed.

(ii) Section 16 of the Act provides, inter alia, that a claim for compensation under section 10 shall contain the particulars set out in a form prescribed by regulation. The Motor Vehicle Accidents Regulations 1992 provide inter alia, that this form including the medical report which forms part thereof), must be completed in all its particulars. A clear reply must be given to each question if not applicable to the claim, "not applicable" must be inserted. Ticks, dashes, deletions and Alterations of confirmed by a signature will be regarded as proper completion of the form.

(iii) The said section further provides that such claims shall be sent by registered post or delivered by hand to the MVA Fund at its registered office or local branch office, and that the MVA Fund shall, in the case delivery by hand at the time of delivery acknowledge receipt thereof and the date of such receipt in writing.

(iv) In order to enable the MVA Fund to deal with this claim it is essential that all the required supporting vouchers and statements accompany this form, and in the case of paragraph 8 of this form it is desirable also to-

(a) attach all medico-legal reports in the possession of the claimant; and

(b) indicate in regard to a claim for future loss of earnings on a separate statement how much loss is calculated.

(v) Written authority for the inspection by or on behalf of the MVA Fund of all the records of the injured or deceased person which may be in the possession of any hospital or medical practitioner should also accompany this form or furnished on request.

1. Party liable for the claim .....

SWAZILAND MVA FUND (SINCEPHETELO MVA FUND)

2. Claimant:

(a) (i) Full name and residential address: .....

.....

(ii) Postal address .....

(iii) Identity No: .....

(b) If the claimant is claiming compensation on behalf of a person other than himself, state-

(i) Capacity in which claimant is acting .....

(ii) Name and address of person(s) on whose behalf compensation is being claimed .....

.....

(iii) Relationship of claimant to such person(s) .....
(in the case of a claim for loss of support or on behalf of other persons, photocopies of relevant marriage and Birth Certificates, as case may be, should accompany the form).

3. Particulars of motor vehicle which caused the loss or damage

(a) Name and address of owner .....

(b) Registration letters and number .....

(c) Name and address of driver at time of accident (*if known*) .....

(d) If the claim is made in terms of regulations 4:

(i) Description of the unidentified vehicle (*if known*) .....

(ii) State on a separate statement attached to this form what efforts were made to establish the identity of the owner or driver of the vehicle .....

4. Particulars of accident in which the vehicle described in paragraph 3 was involved:

   (a) Date ..... Time .....

   (b) Place .....

   (c) Police station to which reported and Police reference number *(if known)* .....

   .....

   (d) Is claimant in possession of a police report and plan?.....
   If so, attach copies.

5. Particulars of any other vehicle involved in accident (if known):
   (i) (ii) (iii)

   (a) Registration letters and number .....

   (b) (i) Name of owner .....

   (ii) Address (*if known*) .....

   (iii) Occupation (*if known*) .....

   (c) Name of driver at time of accident .....

   (d) Name of insurer .....

6. Particulars of person in respect of whose bodily injury or death compensation is claimed

   (a) Full name and address .....

   (b) Sex .....

   (c) Date of Birth .....

   (d) Marital status at date of accident *(state whether never married, married, divorced, widowed or legally Separated)* .....

   (e) If married, state whether in or out of community of property or in accordance with Swazi laws and custom

   .....

   (f) Business or occupation .....

   (g) At the time of the accident was he/she travelling in one of the vehicles described in either paragraph 3 or paragraph 5? *(Yes or No)* .....

   (h) If yes, state registration letters and number of vehicle and whether passenger or driver .....

   (i) If he/she was not travelling as a passenger or driver in one of the vehicles described in either paragraph 3 or paragraph 5 what was his / her mode of conveyance, or was he / she a pedestrian? .....

   j) Name and addresses of usual medical attendant (if any) .....

   (k) Names and addresses of all medical practitioners who attended him / her after the accident (if known) .....

   .....

   .....

   (l) (i) At which hospital or nursing home or other place, if any, did he / she receive treatment after the accident

   .....

   ..... and

   (ii) for what period as in-patient (from ..... to .....

   and / or out-patient (from ..... to .....

(ii) If yes state whether the Labour Commissioner or his/her employer, as the case may be, has been notified that A claim is being lodged against the authorised insurer named in paragraph 1 above (Yes or No)

.....

(iii) If Yes, give date and details of such notification and state by whom given

.....

(iv) If the claimant has already been compensated in terms of the Workmen's Compensation Proclamation, State amount received and Labour Commissioner's reference .....

I hereby declare that to the best of my knowledge and belief all the information contained in this form is true and correct.

Signed at ..... this ..... day of..... 20 .....

As witnesses:

1. .....

2. .....

.....
Signature of claimant (named in paragraph 2) or his / her authorised representative. (If the above signature is not that of the claimant, state the capacity in which the authorised representative is acting.)

MEDICAL REPORT

(PLEASE COMPLETE IN BLOCK LETTERS)

Note - The regulations provide that this report must be completed by the medical practitioner who treated the deceased or injured person for the bodily injuries sustained by him in the occurrence out of which this claim arises or by the Superintendent (or his representative) of the hospital in which the deceased or injured person was treated for such bodily injuries.

(Where blocks are provided for the purpose of a reply to a question place a cross in the appropriate block and if answer is yes, provide appropriate details).

1. Are you satisfied that the person to whom this report relates is the person named in paragraph 6 of the claim form? ..... Yes ☐ No ☐

2. Date when first seen after accident .....

3. Did you treat, him/her at any time before the accident? ..... Yes ☐ No ☐

   If Yes, give date of last such treatment and nature of ailment .....

   .....

4. Are the injuries: ☐ Minor? ☐ Moderately severe? ☐ Severe? ☐

5. Indicate the parts of body injured:

   Head ☐ Chest ☐ Neck ☐ Abdomen ☐

   Back ☐ Upperlimbs ☐ Lowerlimbs ☐ Pelvis ☐

6. (a) Give full details of the injuries and any complication (e.g. Fractured ribs with haemothorax, compound fracture left tibia, disfigurement, etc) .....

   ..... and

   (b) state treatment given to date .....

7. Is permanent disability expected? ..... Yes ☐ No ☐

   If Yes give details .....

   If No, has his / her condition become stabilized? .....

8. Is specialist treatment being given? ..... Yes ☐ No ☐

.....

9. Give full details of nature and expected duration of any future treatment .....

.....

10. Has the injuries aggravated any pre-existing pathological condition? Yes ☐ No ☐

11. Has any such pre-existing pathological condition been aggravated by Yes ☐ No ☐

Effects of trauma? .....

.....

.....

12. If in employment at date of accident, state date when return to employment is expected

.....

13. Where there has been a fatal termination, indicate:

(a) Date of death .....

(b) Cause .....

(c) Did any pre-existing pathological condition contribute to death? Yes ☐ No ☐

(d) If Yes, give full details .....

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14. Please provide any other relevant medical details

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Name of medical practitioner .....

Signature .....

Qualifications .....

Address .....

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Date .....

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(iii) Classification for hospital purposes (hospital patient or private patient)

(m) Was he / she suffering from any physical defects or infirmities immediately prior to the accident? (Yes or No) .....

(n) If yes, give details .....

(o) Name and address of employer at date of accident, and how long employed by such employer *(if more than one)* .....

.....

(p) Was he/she injured or killed in the course at his/her employment?

(q) State his/her income for the 12 months immediately preceeding the accident-

(i) from employment ..... E .....

(ii) from any other source (give details) ..... E .....

..... E .....

Total ..... E .....

7. If the person named in paragraph 6 was fatally injured the following additional information is required in respect of such

(a) Place where death occurred .....

(b) Date of death .....

Attached copy of report on the post mortem examination, (if available)

(c) Is it known whether an inquest has been held? (Yes or No) .....

(d) If known state, in what court .....

date ..... and reference number .....

(e) Names and addresses of all dependants of the deceased whether or not compensation is being claimed on their .....

.....

(f) Names and addresses of the executor of the deceased's estate .....

.....

.....

person the following information is required in respect of each such dependant, *(If compensation is claimed by or on behalf or more than one dependants the information required by the paragraph in respect of each dependant should be set out on a separate statement and attached to this form)*

(a) Full names and addresses .....

(b) Sex .....

(c) Date of Birth .....

(d) Relationship to deceased person .....

(e) Marital status at date of accident (state whether never married, married, divorced, widowed or legally ..... Separated) .....

(f) If married, state whether in or out of community of property or in accordance with Swazi Law and Custom

.....

(g) Business or occupation .....

(h) Is he / she suffering from any physical defects or infirmities ? (Yes or No) .....

(i) If Yes, give full particulars .....

.....

(j) Name and address of employer at date of accident and how long employed by such employer *(if more than one employer state names and addresses of all)* .....

.....

.....

.....

(k) State his / her income or the 12 months immediately proceeding the accident-

(i) from employment ..... E .....

(ii) from any other source (give details) ..... E .....

..... E .....

Total ..... E .....

(l) Details and amount of any inheritance or any other benefits received from the estate or the deceased or accruing from any other source as a result of the death of the person referred to in paragraph 6, other than insurance and / or pension moneys.

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9. Compensation claimed:

Precise details must be given in respect to each of the following items and supported by vouchers where applicable. *(if necessary, the information required by this section may be set out on a separate duly signed and attached to this form)*.

	Item	Amount E
(i)	Hospital expenses	
(ii)	Medical expenses	
(iii)	Estimated future medical expenses	
(iv)	Loss of earnings (*from date of accident to date of hereof*)	
(v)	Estimated future loss of earning	
(vi)	General damages (specify whether for pain and suffering. Permanent disability, etc.)	
(vii)	Loss of support	
(viii)	Funeral Expenses	
	Total	

10. (a) Is the claimant entitled to recover, or has the claimant already recovered, any amount from any other source e.g Employer, medical aid society / or fund (*Yes or No.*)

(b) If yes, give full details and any reference .....

.....

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(c) (i) If the person mentioned in paragraph 6 above was killed or injured in the course of his / her employment is the claimant entitled to compensation under the Workmen's Compensation Proclamation (No. 4 of 1943, as amended? (Yes or No.) .....