Disablement Benefit Claim Form

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memberadmin@legalwise.co.za www.legalwise.co.za

NB. Please attach a certified copy of the Doctor's report confirming that the main Member is disabled.

Please write clearly using CAPITAL letters and one letter per block. Fill in from the left and leave a blank box as a space between words.

1. Main Member's Personal Details

Membership No

Surname

Title

First Name/s

ID No

Date of Birth Y Y Y Y M M D D

Tel No

Tel Mobile

2. Details of Doctor who examined the main Member

Name of Doctor

Practice Address

Postal Code

Tel No

Tel Mobile

Date of Accident Y Y Y Y M M D D

For Office Use Only

Date that Member reported Incident Y Y Y Y M M D D

Main Member's Signature

Date Y Y Y Y M M D D