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GOVERNMENT GAZETTE

OF THE

REPUBLIC OF NAMIBIA

R0,90

WINDHOEK — 11 November 1991

No. 294

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Government Notices

MINISTRY OF FINANCE

No. 125 1991

MOTOR VEHICLE ACCIDENTS FUND REGULATIONS, 1990

The Minister of Finance has under section 15 of the Motor Vehicle Accidents Act, 1990 (Act 30 of 1990) made the regulations set out in the Schedule.

SCHEDULE

Definitions

1. In these regulations, unless the context indicates otherwise, words and phrases shall have the meaning assigned thereto in the Act, and -

“MVAF” means the Motor Vehicle Accidents Fund;

“the Act” means the Motor Vehicle Accidents Act, 1990 (Act 30 of 1990).

Repealed by Gov N/208/8.10.01

Liability of MVAF for loss or damage caused by unidentified vehicle

2. (1) The liability of the MVAF in terms of the Act in respect of claims for bodily injury or death arising from the driving of a motor vehicle in a case where the identity of neither the owner nor the driver can be established, (hereinafter referred to as the unidentified motor vehicle) shall be subject to the following conditions:

- (a) The MVAF shall not incur any liability unless -
 - (i) the said bodily injury or death arose from the negligent or unlawful driving of the unidentified motor vehicle;
 - (ii) the claimant took all reasonable steps to identify the owner or driver of the unidentified motor vehicle;
 - (iii) the claimant submitted, if reasonably possible, within 14 days after he or she was in a position to do so, an affidavit to the police in which particulars of the occurrence that gave rise to the claim are fully set out;
 - (iv) the claimant's inability to obtain judgment in terms of section 6 of the Act is not due to any act or omission on his or her part; and
 - (v) the unidentified motor vehicle (including anything on, in or attached to it) came into physical contact with the injured or deceased person or with any other person, vehicle, conveyance or any other object or objects which directly or indirectly caused or contributed to the injury or death.
 - (b) The liability of the MVAF shall in no case exceed the amount for which an appointed agent would have been liable in terms of the Act had the motor vehicle been identified.
 - (c) The MVAF shall not by virtue of this regulation be obliged to make any payment to the Government, the Workmen's Compensation Commissioner or any other employer by whom compensation is payable in terms of the Workmen's Compensation Act, 1941 (Act 30 of 1941);
 - (d) The MVAF shall not be liable for any money paid or payable to any medical practitioner for medical services rendered by him or her where such services were rendered by the medical practitioner acting in the course and within the scope of his or her service with the Government.
- (2) The provisions of sections 6(2)(c), (d), (e) and (f) and 7 of the Act shall *mutatis mutandis* apply to the liability of the MVAF in terms of this regulation.
- (3) The liability of the MVAF in respect of claims referred to in subregulation (1) shall be subject to the following further conditions:
- (a) A claim for compensation for loss or damage suffered by the claimant shall be delivered to the MVAF within three years from the date of the occurrence which gave rise to the said bodily injury or death and the provisions of section 12 shall *mutatis mutandis* apply in respect of a claim contemplated in this regulation.

- (b) No such claim shall be enforceable by legal proceedings commenced by a summons served on the MVAFF before the expiration of a period of 120 days as from the date on which the claim was sent or delivered by hand, as the case may be, to the MVAFF as provided for in paragraph (a):

Provided that if the MVAFF repudiates in writing liability of the claim before the expiration of the said period, the claimant may at any time after such repudiation serve summons on the MVAFF.

- (c) The MVAFF shall not incur any liability unless the summons arising from the provisions of paragraph (b) has been properly served on the MVAFF within three years and 120 days from the date of the occurrence which gave rise to the claim: Provided that the court shall not hear the action before the claimant concerned has given security to the satisfaction of the court for the costs of the MVAFF in connection with such action.

(4) The provisions of paragraphs (a) and (c) of subregulation (3) shall apply to all claimants, irrespective as to whether they are subject to any legal disability.

(5) The MVAFF shall at any time after having received a claim in accordance with the provisions of subregulation (3)(a), be entitled to require from any person who has suffered bodily injury giving rise to the claimant's claim to submit himself or herself, at the request of the MVAFF or any of its representatives or any person so instructed by the MVAFF, to interrogation by such parties at a place indicated by the MVAFF or such representative or person and, at the request of the MVAFF or such representative or such person, to make a sworn statement setting out in full the circumstances of the alleged occurrence on which his or her claim is based.

(6) At any time after making payment to the claimant in settlement of a claim under this regulation, whether in terms of a judgment or otherwise, and in consideration of the said payment, the MVAFF shall be entitled to the cession of any claim which the claimant may have against the owner or driver of the unidentified motor vehicle, or any person responsible in law for the acts of such owner or driver.

Claim form and medical report

3. (1) The claim form and medical report shall be combined in form MVAFF 1 as set out in the Annexure hereto.

(2) A claim by a supplier for the payment of incidental expenses in terms of section 6(5) of the Act shall be made in form MVAFF 2 as set out in the Annexure hereto.

(3) Any form provided for in this regulation which has not been completed in all its particulars shall not be acceptable as a claim in terms of the Act or these regulations.

Giving of information by owner or driver of motor vehicle

4. The owner and the driver, if he or she is not the owner, shall, in a case where the provisions of section 9 of the Act apply, furnish the required particulars in form MVAFF 3 as set out in the Annexure hereto, and forward the said form within the

period contemplated in that section to any appointed agent or to the Director, MVAF, Private Bag 13295, Windhoek.

Statistics

5. (1) Every appointed agent shall furnish the Director -
- (a) within 14 days after the close of every month, in form MVAF 4 as set out in the Annexure hereto, with particulars of all claims for compensation received by the agent during such month;
 - (b) weekly with particulars of payments made during the previous week in respect of such claims, in form MVAF 5, as set out in the Annexure hereto;
 - (c) within 14 days after the close of each financial year of the MVAF with an estimate of undischarged liabilities in respect of all claims which were on hand at the end of the financial year in question and which were not yet finalized, in form MVAF 6, as set out in the Annexure hereto; and
 - (d) within 14 days after 31 March and 30 September of each year with particulars of the recovery of compensation in terms of section 14 of the Act during the preceding six months, in form MVAF 7, as set out in the Annexure hereto.

(2) The Director may in writing call upon any appointed agent to make available to the Director such information with regard to such statistics as the Director may deem desirable, and an appointed agent shall, within 30 days from the date of receipt of such a written request, supply the information called for.

(3) An appointed agent who fails to comply with any provision of subregulation (1) or (2) shall be guilty of an offence and liable on conviction to a fine not exceeding R2 000.

ANNEXURE

PRESCRIBED FORMS

Form No.	Purpose
MVAF 1	Claim for loss or damage and medical report.
MVAF 2	Claim for medical services.
MVAF 3	Accident report form (Motor accidents).
MVAF 4	Statistics: Claims received.
MVAF 5	Statistics: Claims paid.
MVAF 6	Statistics: Estimates of outstanding liabilities.
MVAF 7	Statistics: Right of recourse.

MVAF 1

CLAIM FOR LOSS OR DAMAGE AND MEDICAL REPORT

Notes:

- (i) A separate form must be completed and lodged in respect of each person or deceased person for whose injury or death is claimed.
- (ii) In order to deal with this claim at an early date it is essential that all the required supporting vouchers and statements should accompany this form and in the case of paragraph 9 of this form it is desirable to also -
- (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 such loss is calculated.
- (iii) Written authority for inspection by or on behalf of the MVAF or its appointed agent of all records regarding the injured or deceased person which may be in the possession of any hospital or medical practitioner must accompany this form.
- (iv) Paragraphs 2 to 5 as well as paragraph 6(a) below must be completed before this form is submitted to the medical practitioner for completion of the medical report.
- (v) Where blocks are provided for the purpose of replying to a question, place a cross in the appropriate block.

1. PARTY LIABLE FOR THE CLAIM
 (APPOINTED AGENT OR MAAF)

2. CLAIMANT:

(a) (i) FULL NAME AND RESIDENTIAL ADDRESS OF CLAIMANT

 (ii) Citizenship (iii) Identity/Passport No.
 (iv) Telephone No.: Home Work

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

(i) Capacity in which claimant is acting

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

(iii) Identity/Passport number of such person(s)

(iv) Relationship of claimant to such person(s)

(In event of a claim for loss of support or on behalf of another person, photocopies of relevant marriage and/or birth certificates, as the case may be, should accompany this form.)

3. PARTICULARS OF MOTOR VEHICLE WHICH CAUSED THE LOSS OR DAMAGE:

- (a) Registration letters and number (i) Make
- (ii) Type of body
- (b) Name and address of owner
-
- (c) Name and address of driver at time of accident
-
- (d) IF THE CLAIM IS MADE IN TERMS OF REGULATION 2:
 - (i) Description of 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 at which reported and Police reference number (if known)
-
- (d) Detailed account of the accident, including a rough sketch of the scene of the accident supported by sworn statements by claimant and eyewitnesses (if any) (must be furnished on a separate statement attached to this form) Also attach copies of the Police report and plan, if available.

5. PARTICULARS OF ANY OTHER VEHICLES INVOLVED IN ACCIDENT (IF KNOWN)

- (i) (ii)
- (a) Registration letters and number

- (b) (i) Name of owner (if known)
- (ii) Address (if known)
- (iii) Occupation (if known)

- (c) (i) Name of driver at time of accident
- (ii) Address (if known)

(If more than two vehicles were involved the particulars should be set out on a separate statement attached to this form.)

6. PARTICULARS OF PERSON IN RESPECT OF WHOSE BODILY INJURY OR DEATH COMPENSATION IS CLAIMED:

(a) Full name and address

(b) Identity/Passport No.

(c) Sex (d) Date of birth

(f) Marital status at date of accident: never married married divorced
 widowed legally separated

(g) If married: in community of property out of community of property
 by customary union

(h) Business of occupation

(i) At the time of the accident was he/she travelling in one of the vehicles described in either paragraph 3 or paragraph 5?
 YES NO

(j) If YES, state: (i) Registration letters and numbers of vehicles;
 and (ii) whether as a passenger or driver

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

- (l) name and address of usual medical practitioner (if any)
- (m) Names and addresses of all medical practitioners who attended him/her after the accident (if known)
- (n) (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)
- (iii) Classification for hospital purposes: hospital patient
private patient
- (iv) Hospital reference number (if known)
- (o) Was he/she suffering from any physical defect or infirmity immediately prior to the accident?
YES NO
- (p) If YES, give details
- (q) (i) Name and address of employer at date of accident (if more than one employer, state names and addresses of all)
- (ii) Period in his employment, from to
- (iii) Nature of work
- (iv) Date of resumption of work
- (r) Was he/she injured or killed in the course of his/her employment YES NO
- (s) State his/her income for the 12 months immediately preceding the accident -

(i) from employment R.....

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

Total R.....

7. IF THE PERSON MENTIONED IN PARAGRAPH 6 WAS FATALLY INJURED THE FOLLOWING ADDITIONAL INFORMATION IS REQUIRED IN RESPECT OF SUCH PERSON:

(a) Place where death occurred (b) Date of death

(c) Is it known whether an inquest was held? YES NO

(d) If known, state in what court date
and reference number (attach a copy of report on the post mortem examination, if available).

(e) Name and address of the executor of the deceased's estate

8. IF THE PERSON MENTIONED IN PARAGRAPH 6 WAS FATALLY INJURED AND COMPENSATION IS CLAIMED BY OR ON BEHALF OF DEPENDANTS OF THAT PERSON THE FOLLOWING INFORMATION IS REQUIRED IN RESPECT OF EACH SUCH DEPENDANT.

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

(a) Full name and address

(b) (i) Identity/Passport No.

(c) Sex (d) Date of birth

(e) Relationship to deceased person

(Attach a photocopy of relevant marriage and/or birth certificates, as the case may be)

(f) Marital status at date of accident: never married married divorced
widowed legally separated

- (g) If married: in community of property out of community of property
by customary union
- (h) Business or occupation
- (i) If he/she suffering from any physical defect or infirmity? YES NO
- (j) If YES, gave full particulars
- (k) Name and address of employer at date of accident and how long employed by such employer (if more than one employer, state names and address of all)
.....
.....
- (l) State his/her income for the 12 months immediately preceding the accident -
 - (i) from employment R.....
 - (ii) from any other source (give details) R.....
 - Total R.....
- (m) Details and amount of any inheritance or any other benefit received from the estate of 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
.....
.....
.....

9. COMPENSATION CLAIMED:

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

(See also Note (ii) at top of form.)

Item	Amount
	R
(i) Hospital expenses (state hospitals)
(ii) Hospital expenses (other hospitals)
(iii) Medical expenses
(iv) Estimated future medical expenses
(v) Loss of earnings/support from date of accident to date hereof
(vi) Estimated future loss of earnings/support
(vii) Funeral expenses
(viii) General damages (pain and suffering, permanent disability, etc.)..
Total	R.....

10. IF THE PERSON MENTIONED IN PARAGRAPH 6 ABOVE WAS KILLED OR INJURED IN THE COURSE OF HIS/HER EMPLOYMENT STATE:

(i) Whether the claimant is entitled to compensation under the Workmen's Compensation Act.

YES NO

(ii) If the claimant has already been compensated in terms of the Workmen's Compensation Act, state amount received

and Workmen's Compensation Commissioner's reference

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

Signed at this day of19..

As witnesses:

1.

Signature of claimant (mentioned in paragraph 2)

or his/her authorised representative. (If the

above signature is not that of the claimant,

proof in writing that he/she is authorised to act

2. as representative of the claimant must accompany

this form.)

MEDICAL REPORT

Note:

(i) This report must be completed by the medical practitioner who treated the deceased or injured person for the bodily injuries sustained by him or her in the occurrence from which the claim arises or by the superintendent (or his or her representative) of this hospital in which the deceased or injured person was treated for such bodily injuries.

(ii) Where blocks are provided for the purpose of replying to a question, place cross in the appropriate block.

1. (a) Name of person to whom this report relates

(b) Are you satisfied that this is the person mentioned 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. Parts of body injured and degree of injuries:

Head Chest Neck Abdomen Back Upper Lower Pelvis
limbs limbs

Minor

Fairly severe

Severe

5. (a) Give full details of the nature of the injuries and any complications (e.g. fractured ribs with haemothorax, compound fracture left tibia, disfigurement, etc.)

.....
.....
.....
.....
.....
.....

(b) State treatment given to date

.....
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.....
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.....
.....
.....
.....
.....
.....
.....
.....
.....

6. Is permanent disability expected? YES NO

If YES, give full details

.....
.....

If NO, has his/her condition stabilised?

7. Is specialist treatment being given? YES NO

If YES, give name and address of specialist

.....

8. (a) Is future medical treatment foreseen? YES NO

- If YES:
- (i) What will the probable nature of such treatment be and in respect of which injuries
.....
 - (ii) Expected date thereof
 - (iii) Expected duration thereof

(iv) Estimated cost thereof (if possible) R.....

(c) Is hospitalisation foreseen in connection with the future treatment referred to in (a) above?

YES NO

(d) If YES, state:

(i) Expected date of such hospitalisation

(ii) Expected duration thereof

9. Have the injuries aggravated any pre-existing pathological condition?

YES NO

10. Has any such pre-existing pathological condition aggravated the effects of trauma?

YES NO

11. If the answer to either 9 or 10 above is YES, give full details

12. Has the person been confined to a hospital/nursing home? YES NO

If YES, state:

(a) Name and address of hospital/nursing home

(b) Hospital reference number (if known)

(c) Date when discharged or when discharge is expected

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

14. In the case of fatality, state:

(a) Date of death (b) Cause

(c) Did any pre-existing pathological condition contribute to death?

YES NO

(d) If YES, give full details

Name of medical practitioner	Qualifications
Signature	Date
Address
.....

MVAF 2

CLAIM FOR MEDICAL SERVICE 5

Notes:

- (i) A separate form must be completed and lodged with the MVAF or its appointed agent, as the case may be, in respect of each third party to whom goods have been supplied or services rendered.
- (ii) Section 6(5) and 6(6). A clear reply must be given to each question, and if a question is not applicable to the claim "not applicable" must be inserted. A form that contains ticks, dashes, deletions and alterations which are not confirmed by a signature will not be regarded as being properly completed.
- (iii) The claim must be sent by registered post or delivered by hand to the MVAF or its appointed agent.
- (iv) Where blocks are provided for the purpose of replying to a question, place a cross in the appropriate block.

1. Party liable for the claim

.....
 (appointed agent or MVAF)

2. Claimant (medical or dental practitioner/nurse/supplier/pharmacist/hospital/nursing home):

(a) Full name

.....

(b) Registered qualifications (if applicable)

.....

(c) Address

.....

3. Third party (to whom service has been rendered or is being rendered):

(a) Full name

.....

(b) Registration letters/and numbers of motor vehicle which caused his/her injuries

.....

(c) Injuries sustained: (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 purpose:

Private patient Hospital

(g) Hospital reference no

4. Claim for 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.....

5. Claim for treatment in hospital(s)/nursing home(s):

(a) Period of treatment -

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.....

.....

SIGNATURE

.....

DATE

NVAF 3

NVAF REPORT FORM

(Notice of an accident in terms of Section 9(1) of the Act)

N.B. (i) If a motor vehicle accident in which a person is injured or killed is not reported to the NVAF or its appointed agent within 14 days the compensation paid to the third party may be recovered from the owner or driver.

(ii) Where blocks are provided for the purpose of replying to a question, place a cross in the appropriate block.

Date of accident

1. Motor vehicle:

(a) Registration letters/No Type of body

(b) Propulsion: Petrol Diesel Gas Electricity Other None

2. Owner:

Name Occupation

Postal address

Telephon No: Business Home

3. Driver:

Name Occupation

Postal address

Telephone No.: Business Home

Driver's Licence No. Date issued

Endorsements (if any)

Physical/Mental defects (if any)

.....

4. Other vehicle(s) involved in accident concerned:

	(i)	(ii)	(iii)
(a) Registration No
(b) Name of owner
(c) Address of owner
(d) Name of driver
.....
(e) Address of driver
.....

5. Witness(es) of accident:

	(i)	(ii)	(iii)
(a) Name
(b) Address
.....

6. Person(s) injured or killed:

	(i)	(ii)	(iii)
(a) Name
(b) Address
.....

7. Accident:

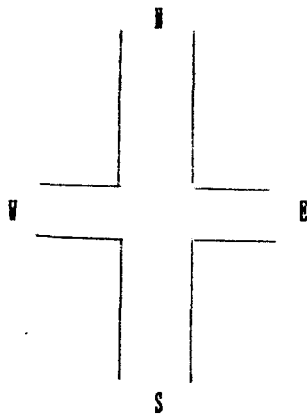
- (a) Date (b) Time
- (c) Place
- (d) Police station at which reported
- (e) Police reference number

8. Conditions during accident:

- (a) Weather conditions: Sunny Dark Cloudy Rain
- (b) Visibility: Good Reasonable Bad
- (c) Road surface: Gravel Sand Tar
- (d) Street lights: On Off
- (e) Own vehicle lights: Bright Dim None
- (f) Other vehicle lights: Bright Dim None
- (g) Speed at time of accidentkm/h

9. Sketch plan of accident:

(Furnish approximate distances)



I

W E

S

10. Detailed description of accident:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

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

Date

.....

Signature of driver

.....

Signature of owner

NVAF 4

CLAIMS RECEIVED

(Must be completed in duplicate)

Name of appointed agent
Financial year during which claims arose Return no.
..... month ending19.....

Claim No.	Remarks
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.

- 15.
- 16.
- 17.
- 18.
- 19.
- 20.

Administration costs:

Number of claims at R..... per claim = R.....

.....

Date

Certified correct

Signature

MINISTRY OF FINANCE

No. 126

1991

**NOTIFICATION OF AGENTS APPOINTED TO HANDLE CLAIMS
ON BEHALF OF MOTOR VEHICLE ACCIDENTS FUND AND
CLAIMS IN RESPECT OF WHICH THEY ARE LIABLE**

In terms of subsection (2) of section 5 of the Motor Vehicle Accidents Act, 1990 (Act 30 of 1990) it is hereby notified that the companies mentioned in the Schedule below have been appointed under subsection (1) of the said section 5 as agents for the handling of claims on behalf of the Motor Vehicle Accidents Fund.

Every agent so mentioned shall handle all claims arising from accidents which occurred on the days of a month indicated opposite the agent's name.

SCHEDULE**APPOINTED AGENTS AND CLAIMS FOR WHICH THEY ARE
LIABLE**

<u>Appointed Agent</u>	<u>Day of Month</u>
Santam Namibia Ltd.	1 — 14
Mutual and Federal Insurance Company of Namibia Ltd.	15 — 25
Insurance Company of Namibia Ltd.	26 — 31