Statutory Instrument No. 56 of 2000

MOTOR VEHICLE ACCIDENT FUND ACT, 1998
(No. 6 of 1998)

MOTOR VEHICLE ACCIDENT FUND REGULATIONS, 2000

(*Published on 15th September, 2000*)

ARRANGEMENT OF REGULATIONS

REGULATION

IN EXERCISE of the powers conferred on the Minister of Finance and Development Planning by section 25 of the Motor Vehicle Accident Fund Act, 1998, the following Regulations are hereby made —

Citation

1. These Regulations may be cited as the Motor Vehicle Accident Fund Regulations, 2000.

Rate of levy

2. For purposes of section 11(2) of the Act, a levy of nine and a half (9.5) thebe per litre shall be retained by the seller on every litre of fuel sold by him, or by the importer on every litre of fuel imported, other than for resale and such levy shall be paid over to the Fund by the twenty fifth day of the month following the date of sale or importation.

Exemption from payment of fuel levy

3. (1) No fuel levy shall be payable in respect of fuel utilised for the purposes of —

(*a*) driving farm machinery or vehicles during the actual course of farming and ranching activities;

(*b*) grinding mill;

(*c*) driving railway rolling stock; and

(*d*) operating stationary equipment:

Provided that payment shall first be made on all fuel as prescribed in regulation (2) and thereafter such levy shall be refunded by the Fund on application.

(2) If a seller or importer proves to the satisfaction of the Fund that fuel was utilised for the purposes set out under subregulation (1) and the levy paid therefor, the Fund shall, upon an application being made to it, repay the levy.

(3) An application made under subregulation (2) for the repayment of fuel levy shall be made to the Fund —

(*a*) in writing in the form set out in Form A of the Schedule and shall contain or be accompanied by such evidence that fuel was utilised for the purposes stated under subregulation (1); and

(*b*) within three months of the utilisation of fuel for the aforesaid purposes.

(4) Any person aggrieved by the refusal of the Fund to repay a levy may, within thirty days after receiving notification of the decision, appeal to the Board.

(5) In this regulation, "railway rolling stock" means a vehicle propelled by mechanical power of which the engine uses fuel for propulsion, and "stationary equipment" includes an electricity generator or a water pump that uses fuel in order for it to operate.

Claim for compensation

4. (1) A claim for compensation against the Fund under section 19 of the Act shall be made in Form B of the Schedule which shall include a duly completed medical report in the form marked as Appendix B1 attached thereto and a statement of the accident in question in the form marked as Appendix B2 attached thereto.

(2) Where a person is entitled to compensation as a third party in terms of section 12(5) of the Act, he may claim the amount due from the Fund on Form C of the Schedule.

Requirement of power of attorney

5. Whenever a claimant is represented by an attorney such attorney shall prove his mandate to the Fund by filing an appropriate power of attorney.

Determination of liability and compensation

6. (1) At any time after receiving a claim for compensation the Fund shall first determine the liability of the Fund.

(2) Where the Fund finds that the claimant is entitled to compensation, or is adjudged to be liable, the Fund shall determine the amount of the compensation payable and such compensation shall be calculated or limited to the sum prescribed in accordance with the Act.

(3) The Fund may require a medical examination to be conducted at its own expense by an independent medical practitioner appointed by the Fund:

Provided that the cost of any other medical examinations shall only be met where the cost has been incurred with the Fund's prior written approval.

(4) The provisions of this regulation shall apply *mutatis mutandis* in respect of actuarial computations performed by an actuary approved by the Board.

Manner of delivery of notices and determinations

7. (1) Any notice or determination made by the Fund shall be delivered by —

(*a*) hand to the claimant who shall acknowledge receipt thereat in writing;

(*b*) registered post to the address furnished in the claim form or to the offices of his legal representative.

(2) A claimant's statement of dissatisfaction made in terms of section 20 (2) of the Act shall be delivered to the office of the Fund by hand and the Fund shall acknowledge receipt thereof or by registered post.

Compensation for funeral expenses

8. For purposes of section 15(12) of the Act, the compensation payable by the Fund in respect of any funeral, including burial, shall not exceed P5000.

Reporting of vehicle accidents Cap. 69:01

9. For purposes of section 18 of the Act, the owner ordriver of a motor vehicle involved in an accident shall make a report of the accident to the police in the manner and form prescribed from time to time in the Road Traffic Act.

Revocation of S.I. 113 of 1986

10. The Motor Vehicle Insurance Fund Regulations, 1986 are hereby revoked.

SCHEDULE

FORM A

Reg. 3 (3)

APPLICATION FOR LEVY REBATE

IMPORTANT: Please attach all receipts. Claims without receipts will not be paid.

Name : .....Tel:.....
Address: .....
.....
.....
.....

	PURCHASES		
Supplier	Purpose for which used* (see below)	receipt no / date	litres
1.			
2.			
3.			
4.			
5.			
6.			

*Stationery equipment, *grinding mill, *railway stock, *borehole engine, *farm vehicles (state registration number), *electricity generator.

I, ... of .....do hereby certify that the above information is true and correct and that there is no duplication in amounts claimed. I certify that the fuel was utilised for the purpose stated above.

Dated at ..... on this..... day of .....
.....
Signature of deponent
.....

FOR OFFICIAL USE

Claim Number : .....

....
Checked by *Date*

....
Approved by *Date*

Motor Vehicle Accident Fund

Form B

CLAIM FOR COMPENSATION

IMPORTANT NOTES

i) *If the person claiming is a minor this form must be filled in by the parent or legal guardian.*
ii) *The Medical Form attached hereto must be completed by the doctor who actually treated the person who was injured or killed.*
iii) *Do not go to the expense of having further medical reports done for the purposes of supporting this claim as such medical investigation will be done by the Fund if necessary.*

Section 1 DETAILS OF PERSON CLAIMING COMPENSATION

a)	Surname:		
b)	First Names:		
c)	Date of birth:	Place of birth:	
d)	Omang or ID No:	Passport No:	
e)	**Status** (√) Single☐ Married☐ Divorced☐ Widowed☐ Separated☐		
f)	Residential Address:		
g)	Postal Address:		
h)	Telephone No:	Home/Cell:	Work:

Section 2 DETAILS OF PERSON INJURED OR KILLED

a)	Surname:		
b)	First Names:		
c)	Date of birth:	Place of birth:	
d)	Omang or ID No:	Passport No:	
e)	Status (√) Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐		
f)	Residential Address:		
g)	Postal Address:		

h)	Telephone No:	Home:	Work:
i)	Name of usual doctor:		
j)	Was the person suffering from any illness or disability at the time of the accident? Yes ☐ No ☐		
	State nature of illness or disability:		
k)	Was this person injured or killed in the course of employment? Yes ☐ No ☐		

Section 3 **DETAILS OF ACCIDENT**

a)	Date of accident:		Time:
b)	Place of accident:		
4.	Please state what the person who was injured or killed was doing at the time of the accident. Tick √ the correct box. Was he or she —		
a)	Driving a vehicle? ☐		Registration No:
b)	Riding a Motor cycle? ☐		Registration No:
c)	Driving an animal drawn vehicle ☐		
d)	A passenger in a vehicle? ☐		Registration No:
	State name of driver:		
e)	Pedestrian ☐	If the person was a pedestrian state if he or she was — Walking ☐ Running ☐ Standing ☐	
5.	Registration number of vehicle which caused the accident:—		
6.	To which police station was the accident reported?		
	Date of Report:		Time of report:
•	Attach Police Accident Report.	• Complete Appendix B2	

Section 7 DETAILS OF CLAIM

Fill in only those sections which apply to you.

a)	Past Loss Of Earnings	I am claiming for past loss of earnings	Yes☐ No☐

Period for which salary lost:— hours/days/weeks/months

State amount of lost earnings — P

- Attach copies of pay slip for a period of six (6) months prior to the accident.

b)	Future Loss Of Earnings	I am claiming for future loss of earnings	Yes ☐ No☐

- Attach copies of pay slip for a period of six (6) months prior to the accident

Note that the Fund will conduct the investigation as to your future loss of earnings.

c)	Past Medical Expenses	I am claiming for past medical expenses	Yes ☐ No☐

- Attach copies of receipts for medical expenses you had to pay for treatment of injuries suffered in the accident by the injured person or deceased.

d)	Future Medical Expenses	I am claiming for future medical expenses	Yes ☐ No☐

Note that the Fund will conduct the investigation as to your future Medical expenses.

e)	I am claiming compensation for grief caused by the death of a minor.		Yes ☐ No☐
f)	Loss of Support	I am claiming for loss of support	Yes ☐ No☐

If deceased was self employed attach copy of bank statement of balance over period of one year before death.

If deceased was employed attach copy of pay slip for period of six months before the accident.

- Attach a list showing the names and ages of the dependents of the deceased.

g)	Funeral Expenses	I am claiming for funeral expenses	Yes ☐ No☐

- Attach receipts of funeral expenses.

h)	General Damages	I am claiming general damages	Yes ☐ No☐

- Note that the Fund will conduct the investigation in order to asses your pain, suffering, loss of earning capacity, loss of amenities, disfigurement, disability etc. Do not go to the expense of obtaining further medical reports. This will be done by the Fund if necessary.

Section 8 **MITIGATION OF LOSS**

a)	Was the injured person or deceased on Medical Aid?	Yes ☐ No☐
	If so state the name of the medical aid or scheme:-	
b)	Is there a claim under Workmans Compensation?	Yes ☐ No☐
	State the amount, if any, paid under Work's Compensation Act.	P
c)	Is there a claim under Insurance law or policy?	Yes ☐ No☐
	State the amount paid or due under Insurance law or policy.	P
e)	Is there any money due under an employment contract?	Yes ☐ No☐
	State the mount paid or due under any employment contract.	P
f)	State any amount received or due as a result of the accident.	P

I certify that the information set out in this claim form is true to the best of knowledge and belief. I understand that deliberately giving false information may result in loss of my right to compensation.

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

x.....x
Signature of claimant or legal guardian.

.....
Witness

x.....x
Legal Representative

.....
Witness

CLAIM FOR COMPENSATION BY CREDITOR

IMPORTANT NOTE

In terms of section 12 (5) of the Act any creditor of a person entitled to compensation may claim directly from the Fund monies owing for services rendered or goods supplied in respect of the injured party or deceased provided that liability has accrued to the Fund.

Section 1 DETAILS OF PERSON OR ORGANIZATION CLAIMING

a) Name:

b) Physical Address:.....

c) Postal Address: .....

h) Telephone No:	Home:	Work:	Fax:

SECTION 2 DETAILS OF THE DEBTOR

a) Surname:

b) First Names:

c) Omang or ID No:	Passport No:

d) Postal Address: .....

e) Telephone No:	Home:	Work:

Section 3 DETAILS OF ACCOUNT

a) Attach detailed statement of account itemizing date and nature of service rendered.

b) Attach detailed statement of account itemizing date and nature of goods delivered.

I certify that the information set out in this claim form is true to the best of knowledge and belief. I understand that deliberately giving false information may result in loss of my right to recovery of the debt/s.

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

x.....x

Signature of claimant or company rep.

.....

as Witnesses or Company Stamp

x.....x

Legal Representative

MEDICAL REPORT

APPENDIX B1

This report is to be completed by the medical officer who first treated the injured party or deceased after the accident in question.

1. Name of person to whom this report relates:-

2. Date when first seen after the accident:-

3. Did you ever treat this person prior to the accident? Yes ☐ No ☐

If Yes give details of last such treatment and nature of ailment:-

4. Parts of body injured and degree of severity:-

	Head	Chest	Neck	Abdomen	Back Limbs	Upper Limbs	Lower	Pelvis
Minor	☐	☐	☐	☐	☐	☐	☐	☐
Moderate	☐	☐	☐	☐	☐	☐	☐	☐
Severe	☐	☐	☐	☐	☐	☐	☐	☐
Catastrophic	☐	☐	☐	☐	☐	☐	☐	☐

5. Summarise nature of injuries and any complications:-

6. Specify details of treatment given to date:-

7. Is permanent disability expected? Yes ☐ No ☐ If Yes Please give details:-

8. Has the patient's condition stabilised? Yes ☐ No ☐

If No please give details of further treatment that will be necessary:-

9. Have injuries aggravated a pre-existing medical condition? Yes ☐ No ☐

If Yes Please give detail of such condition:-

10. Do you recommend obtaining a specialist medico-legal report? Yes ☐ No ☐

11. Date and period of hospitalisation if any:-

12. When do you expect patient to be fit for work:-

13. In case of death state:-	Date:-	Cause:-
Did any pre-existing pathological condition contribute to the cause of death?		
Yes ☐ No ☐ If Yes Please give details:-		

Name of Practitioner..... Qualifications .....

Contact Phone Number .....

Date..... Signature.....

Appendix B2

Statement of Accident

1. The following is a list of witnesses to the accident:-

Name	Address	Phone Number
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

2. The following is how the accident happened:-

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Signed: ..... Date .....

Form C

Motor Vehicle Accident Fund

CLAIM FOR COMPENSATION BY CREDITOR

IMPORTANT NOTE

In terms of section 12 (5) of the Act any creditor of a person entitled to compensation may claim directly from the Fund monies owing for services rendered or goods supplied in respect of the injured party or deceased provided that liability has accrued to the Fund.

Section 1 **DETAILS OF PERSON OR ORGANIZATION CLAIMING**

a) Name:			
b) Physical Address:			
c) Postal Address:			
h) Telephone No:	Home:	Work:	Fax:

SECTION 2 **DETAILS OF THE DEBTOR**

a) Surname:		
b) First Names:		
c) Omang or ID NO:		Passport No:
d) Postal Address:		
e) Telephone No:	Home:	Work:

Section 3 **DETAILS OF ACCOUNT**

a) Attach detailed statement of account itemizing date and nature of service rendered.

b) Attach detailed statement of account itemizing date and nature of goods delivered.

I certify that the information set out in this claim form is true to the best of knowledge and belief. I understand that deliberately giving false information may result in loss of my right to recovery of the debt/s.

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

x.....x
Signature of claimant or company rep.

.....
As Witnesses or Company Stamp

.....
Legal Representative

MADE this 25th day of August, 2000.

B. GAOLATHE,
Minister of Finance and Development Planning.

L2/7/273