

CLAIM FORM FOR WORKMEN'S COMPENSATION

POLICY NO. : _____ Date of Last Payment of premium : _____

SECTION 1 - EMPLOYER DETAILS

1. Name of Employer _____
2. Contact Details: (tel): _____ (fax): _____
 (mobile): _____ (web): _____
 (email): _____
 (postal): _____ (code): _____ (town/ city): _____
3. Nature of Business _____

SECTION 2 - INJURED EMPLOYEE DETAILS

4. Injured Employee Names: _____
 (mobile): _____ (email): _____
 (postal): _____ (code): _____ (town/ city): _____
5. (a) Occupation? _____ (b) Age? _____ (c) Married or Single? _____
6. Is the injured Employee related to the Employer? Yes No
 If so, what is the relationship? _____
7. Was the Injured Workman in the employ of the Insured or in the employ of a Contractor? _____
 If the latter. Name and Address of the Contractor and nature of contract :

8. Was the Injured Workman's employment casual or regular ? _____
 If the former, state how often employed _____
 If the latter, state how long he had been employed by you or such Contractor prior to the accident.

9. Give rate of pay including allowances at the time of the Accident. (state whether per day, week or month). _____
10. If apprentice, learner or improved, state his terms of remuneration to end of apprenticeship and how much he might then expect to earn. _____
11. State fully the nature of the work he was doing at the time of the Accident.

12. How did the Accident occur?

13. Where did the Accident occur? _____
14. When did the Accident occur? Date : _____ Time : _____
15. Give names and addresses of witnesses of the Accident

Name	Tel. No. and Address

16. Was the Accident caused by : (a) Violation of rules ? Yes No
 (b) Carelessness of injured Employee? Yes No
 (c) Any defect of machinery or plant? Yes No
 If so, had such been brought to your attention.

[Redacted]

17. (a) Was the injured person sober at the time of the Accident ? Yes No
 (b) Under whose direction was he at the time of Accident ? [Redacted]
 (c) Was the Accident caused by carrying out such directions ? Yes No

18. Was the injured person suffering at the time of the Accident from ill-health or bodily defect or infirmity of any description ? Yes No

19. Were you aware of such ill-health, defect or Infirmity ? Yes No

20. Has the injured person previously received compensation for an accident sustained either whilst in your service or in that of a previous employer? Yes No

- If so, please state: (a) The date of the Accident [Redacted]
 (b) The amount of the compensation received [Redacted]

21. State as fully as possible the nature of the injuries received
 [Redacted]

22. State to what extent the injured person is disabled, and whether absolutely prevented from following his employment
 [Redacted]

23. State what you consider will be the probable duration of total disablement.
NOTE: It is important that the fullest possible information be given under this head
 [Redacted]

24. Give name and address of the injured workman's Medical Attendant.
 If in Hospital, give name of same :
 [Redacted]

25. At what date and on what hour was the injury first attended to by a Doctor?
 [Redacted]

26. Have you received notification of a Magisterial Enquiry, or of intention to institute any legal proceedings? If so, give full particulars : Yes No

[Redacted]

DECLARATION :

I/We hereby certify that the above statement is a full and true account to the best of my/our knowledge and belief, and I/We undertake to advise the Company promptly of all developments in connection with the claim.

Date _____ Employer's Signature _____

Notice to Employer:- It is a condition of your Policy that no payment must be made, nor any liability admitted, in respect of Accidental Injury to an Employee, until ordered by the Court, or authorized by the Company.

Certificate to be filled up and Signed by an Eye Witness, if possible by the person under whose direction the Workman was at the time of the Accident.

I [Redacted] hereby certify that I was present when the accident occurred to [Redacted]
 On the date of [Redacted] and that it happened as stated in the claim.

Date: _____ Signature _____ Occupation _____