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WORK INJURY BENEFIT CLAIM FORM

Please answer all questions on the claim form fully and clearly and sign & date the form.
(Provide as much information as possible. If the spaces provided are inadequate, please write on & attach a separate sheet of paper.)

Insured's Details

Full name ____

Policy number____

Physical Address____________________Telephone ______________

E-mail address__________________Fax_______________________

Claimants Details

Name____

Identity number_______________________________________

Age ______Height__________weight______marital status ☐ Single ☐ Married

Usual occupation______________position_____________________

Was he in your direct employment or in that of a subcontractor ☐ Yes ☐ No

If yes give more details____________________________________

Status of employment ☐ Casual ☐ Permanent

If in your employ, how long has he been so employed?__________________

If a subcontractor, give the subcontractor's name and

address____

____

____

Please let us know the employee monthly salary

____

____

Accident Details

Date of accident___________________time____________________place_____________

State the precise nature of work he/she was doing at the time of accident

____

____

____

How did the accident occur?

____

____

When did the injured employee cease work as a result of the accident?

From____________to______________

Was he performing duty in which she was employed?______________________________

Was he disobeying rule or order?____

If yes, please state how

____

____

Was the accident due to another person's negligence?____________________________

If yes please give details____

Was the accident due to defect of machinery or plant? ☐ Yes ☐ No

Had such defects been brought to your notice? ☐ Yes ☐ No

Was the injured person under the influence of drugs or alcohol at the time of accident? ☐ Yes ☐ No

Who was in charge?

Name ____

Job title____

Was the injured person suffering from any health or bodily defect at the time of accident? ☐ Yes ☐ No

Were you aware of ill health or not? ☐ Yes ☐ No

State fully the nature of injuries sustained

____

____

State whether such injuries are likely to cause any permanent disability ☐ Yes ☐ No

Name and address of the injured workman's medical attendant

____

____

If in hospital or nursing home, please provide the name and address

____

____

____

Were there any witnesses to the accident? If so, please give their names and address

Name ____

Address____

____

Attach statement from witness

Declaration

I/We hereby declare that the above statements are true to the best of my/our knowledge and belief, and I/We claim in respect thereof the protection of my/our Policy in respect of the accident.

Name…………………………………………………………………………..

Signature……………………………………………Company Stamp…………………

Tittle………………………………………

Date……………………………

_________________________ _____________________________