Cannon
GENERAL INSURANCE

THE WORKMEN'S COMPENSATION CLAIM FORM

To be completed by the employer in case of injury to or Death of a Workman.

1. THE EMPLOYER

a) Name .....

b) Address .....

c) Industry or Business .....

2. THE WORKMAN INVOLVED IN EMPLOYMENT INJURY

a) Name .....

b) Address (Home & Permanent) .....

c) Sex..... Age: .....

d) I.D. No ..... Occupation: .....

e) Academic/Professional qualification/Technical or trade test .....

f) Was the injured workman in your employment? Yes/No. If not was he/she working at the place of accident under the employment of a contractor or others? State details .....

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g) Monthly or Daily earnings at the time of the accident .....

3. THE ACCIDENT

a) Date & Hour .....

b) Place: .....

c) Cause of the Accident .....

If caused by machinery:-

1. State name of machinery & part causing the injury .....

2. Was it fenced or guarded .....

3. Was it in motion when the accident occurred .....

4. Who was responsible for switching on or off .....

5. Who switched it on .....

6. His address .....

7. His permanent/home address if different from above .....

8. State exactly what the injured person was doing when he got injured .....

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If the injury not caused by machinery, (e.g. Fire, a fall, carrying heavy objects) name the cause and give a brief description of how the workman got injured: .....

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Was the injured person under the influence of alchohol/any drink or drugs at the time of the accident

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4. THE INJURY

a) Was it fatal..... If fatal give the names of all the dependants of the deceased workman if known

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b) Particulars of injury (as certified by the Hospital/Company's Doctor) .....

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c) State the probable period of disablement .....

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d) Name the Hospital/Dispensary/Private clinic where he has been treated following the accident

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e) Whether admitted Yes/No..... Date when first treated .....

f) Date of admission..... Date of Discharge .....

g) Attendance as out-patient prior to and/or subsequent to hospitalization

From:..... To: .....

h) Amount expended on treatment .....

i) Who paid for it .....

j) Has he returned to work .....

5. OBSERVANCE OF INSTRUCTIONS

a) Were there standing instructions/notices on how to do the assigned work .....

Briefly explain .....

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b) Was the workman guilty of any misconduct, or disobedient to such instructions or other orders or rules? .....

If so please give particulars .....

c) Whether the injured workman was provided with protective clothing/ guards e.g. gloves, gum-boots, helmets etc..... If yes, state the date of supply.....

d) Was the workman found without protective clothing/guards at the time of the accident? Yes/No

e) Had his immediate supervisor brought to the attention of the insured workman the necessity of wearing protective clothing/guards when former saw the latter without these guards at the time of commencement of his work but before the occurrence on the date of the accident? .....

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f) Is there a Notice informing workmen generally on routine safety precautions .....

6. WITNESSES

State the names, addresses (Permanent & Home) of the persons who witnessed the accident:

a) .....

b) .....

c) .....

7. WITNESS STATEMENTS

Brief statement from the above named persons who witnessed the accident:

a) .....

Name ..... Designation .....

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

b) .....

Name ..... Designation .....

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

c) .....

Name ..... Designation .....

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

The above details are factual to the best of my/our knowledge, information and brief.

Date .....

Signature of Employer .....

Name .....