CLAIM FORM – WORKMEN COMPENSATION INSURANCE

THIS CLAIM FORM IS ISSUED WITHOUT PREJUDICE TO THE LIABILITY UNDER THE POLICY

POLICY NUMBER:	CLAIM NO.:
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THE EMPLOYER/INSURED				
1.	Name of Policyholder			
2.	Business			
3.	Address			
	Phone Number:			
	Cover 1. in excess of GO	OSI 2. Free Cover		
	E INJURED PERSON			
1.	Name	Age	Sex	
2.	Local/Permanent Address			
3.	State occupation/nature of work of the injured person			
4.	Was the injured person engaged in this occupation when the accident occurred? If not, state exactly the nature of the work he was doing at the time of accident.			
5.	Is the injured person in your direct employment? If not give name and address of Contractor, under whom employed and nature of work entrusted to contractor.			
6.	When did the injured person enter your service?(Date of Employment)			
7.	Has the injured person been medically examined or hospitalized? If so, please send copy of Medical report.	Medical Report Enclosed Yes	No	
THI	EACCIDENT			
1.	Date Time	e Pla	ace	
2.	State how this accident occurred			
3.	Date of notice of accident and by whom? If in writing please attach it to this form.			
4.	Time and date when the injured person actually ceased work.			
5.	How long is the disablement expected to last? (Copy of Fitness certificate of attendant doctor to be obtained after returning to work.)			
6.	Was the accident reported to Police or Inspector of Labour (A copy of report to be attached)			
7.	State nature of injury & part of body			

	affected			
8.	Was the injured person under the			
	influence of alcohol or drugs at the			
	time of accident? If yes, give details.			
THE CLAIM				
1.	Does your claim include			
	reimbursement for medical costs?	Yes No		
	Claim Amount			
2.	Does your claim include			
	reimbursement for loss of income (sick	Yes No		
	leave)?			
	Claim Amount			
Is th	Is this claim has been reported to GOSI (excess of GOSI)			
GO	SI this claim yes	no		
If yes please provide details				
If No please provide details of rejecting this claim by GOSI and Letter from GOSI for of this claim				
I declare that to the best of my knowledge and belief these particulars are full and true. I agree to provide any further information that may be required.				
injoi	mation that may be required.			
Plac	ee:			
Date				
240		(Stamp/ Seal of the Company)		
		(Stamp, Star of the Company)		

Documents to be submitted along with the claim form:

- 1. Copy of Employment Contract
- 2. Copy of latest Salary Certificate (for the month before the loss)
- 3. Original Medical Certificates from the attending doctor
- 4. Original Sick leave certificates from the attending doctor where applicable
- 5. Original Medical Invoices and Prescriptions where applicable
- 6. Copy of a valid ID

Additional documents in case of a death case:

- 7. A detailed incident report from the direct manager/ supervisor
- 8. Copy of Police report (where applicable)
- 9. A Certified Copy of the final death certificate, along with the original to be certified and return.
- 10. Autopsy Report.