



## WORKMENS COMPENSATION INSURANCE CLAIM FORM

(Issue of this form is not to be taken as an admission of liability)

Claim No. 

Policy No.	Employers Name :	Business :	Address :

Name of Injured	Age :	Occupation :	Date of joining work :

Is he direct employment or sub-contracting : 

Basic Salary :

Daily / Monthly

Date of Accident :	Place of accident	Time :

When did he stop working :

Time :

On what work was the employee engaged at the time of accident ?

Give exact information as to the circumstances in which the accident happened :

Nature of extent of injury	Name of witness if any	Who is liable for accident	Name of Hospital
			DOA DOD

Date : .....

Employers Signature