WORKMEN'S COMPENSATION – CLAIM FORM

(THE COMPANY DOES NOT ADMIT LIABILITY BY THE ISSUE OF THIS FORM)

POLICY NO: ________________________________

Employer/Insured: ____

Postal Address: ____

Email Address: ____

Business: ____________________________ Date: _____________________________________

SECTION A

DETAILS OF INSURED WORKMAN

a. Full Name: ____

b. Address: ____

c. Occupation and Age: ____

d. Amount of weekly Earnings: ____

e. How long has he/she worked for you? ____

SECTION B

a. The accident happened at _________ am/pm on the ____ day of____________ at (place) ____

b. The injured workman ceased work on the _________ day of ________________________

c. Give details on how the Accident happened: ____________________________________

____

____

____

d. The workman sustained the following injury or has contracted the following disease: _

____

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SECTION C

The workman and address of the witnesses are

1. ____

2. ____

3. ____

Date: ______________________ Signature: ______________________