सानिमा जनरल इन्स्योरेन्स लि.
Sanima General Insurance Ltd.

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Workmen's Compensation
Claim form

1. Full particulars of the accident are to be furnished by the Employer.
2. Giving the under mentioned information does not imply that the injured person is making, or will make a claim
3. His form is sent without prejudice to the terms of policy.
4. If any details or information are not readily available, please forward this form without delay not later than 3 months from the date of the accident and supply the missing details as soon as possible.
5. All written communications received by the Employer concerning the accident to the employees should be forwarded at once to the Company.

The Employer

Name of the Policy Holder……

Business…… No. of Policy……

Address…… Phone No……

The injured Person

Name…… Date of Birth……

Address…… I.D.Card No……

State occupation in which the injured person is employed…… Sex……

On what exact work was he/she engaged at the time of accident……

……

Is the injured person in your direct employ? ☐ Yes ☐ No
Is the injured person under contract? ☐ Yes ☐ No

when did the injured person enter your Service? ……

If 'Yes give name and address of
Contractor and nature of contract ……

……

Is the injured person able to do partial work? ☐ Yes ☐ No

Was the Injured person taken to hospital ☐ Yes ☐ No
If yes, kindly submit/indicate

1. Name of hospital- ……
2 .Date of Admission-……Discharge……

Have you made any other claim in respect of this workman under the;
Present policy or any other policy? ☐ Yes ☐ No
If yes, give Policy/Claim No……

The Accident

Date…… Time ……
Place……
On what date did you receive notice of accident
And from whom ?
State through whose negligence if any, the accident Occurred……

Did the injured workmen actually cease work after the accident and on what date did the worker cease work? ……
Did the accident occur outside your work Premises?
If Yes, give details. ……
……

State full details of accident ……
……

Was the accident due to machinery or gearing? ☐ Yes ☐ No

Was the worker under influence of drugs/drinks
At the time of accident ? ☐ ☐

SAFETY FIRST: What precautions have you taken to prevent a repetition of this similar accident in future ?……
……

To whom was the accident reported……
……
……

Additional Particulars for Fatal cases only

Has the deceased any dependants? ☐ Yes ☐ No

If Yes, state names, addresses, sex, relationship, ages and occupations ……
……
In connections with FATAL cases please forward a copy of Police report and death certificate

……

Statements of Insured Workman's earnings.

The objects of this part of the form is to ascertain the exact average monthly earnings of the injured person and therefore it is very important that the under-mentioned particulars are accurately completed

1 Month & Year	2 TOTAL EARNINGS Wages Salaries Commissions, Bonuses And Overtime Rs. Cts.		Value o Board and/or Lodging and/or other Consideration Rs. Cts.		Please indicate the specific dates, the workman was absent from work.
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
Total earnings in the period From……to……..					Total including allowances Rs…… Monthly Average wage Rs……..

Notes : 1. Please submit in column(2) above total monthly earnings of the worker for 12months's prior to date accident for example, if date accident was 05/03/2018, the earnings that should be submitted are from 06/03/2017 to 05/03/2018 .

2. If the worker's period of service was less than one month, please give the average monthly wages of a workman employed on the same work or if there was no workmen so employed of a workman employed on similar work in the same locality Rs. ……..

The replies given are correct to the best of my/our knowledge or behalf.

Name & Designation: ……

Signature …… Date: ……..

Company Stamp ……