FIRST INSURANCE COMPANY LIMITED
Service beyond expectations

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WORKERMEN'S COMPENSATION CLAIM FORM (WITHOUT PREJUDICE)

EMPLOYER (1) Name of employer and full address	
(2)state (a) name of policy (b) date of last payment of premium	(a) (b)
(3) Nature of Trade or Business?	
INJURED WORKMAN (4) Name and full address (in the case of Africans give particulars of tribes, village, district)	
(5) (a) Occupation? (b) Age? (c) sex? (d) Married or single? (e) Tax or identity number	(a) (b) (c) (d) (e)
(6) Is the injured employee related to the Employer? If so, what is the relationship?	
(7) Was he in your direct employment or in that of a sub-contractor	
(8) If in your employment, how long has he been so?	
(9) Give rate of pay PER MONTH at the time of accident	
(10) State FULLY the nature of the work he was doing at the time of accident.	
(11) How did the accident occur?	
(12) (a) Where did the Accident occur? (b) District?	(a) (b)
(13) (a) When did the accident occur? (b) When did the injured employee cease work on account of accident?	At……m. on the……..day…….....19……. At ……...m. on the……day of……19……..
(14) Was The Accident Caused By: (a) Violation of rules? (b) Carelessness of injured workman? (c) Carelessness of any other person? If so who? (d) Any defect of machinery or plant? (e) Had such defect been brought to your notice? (f)	(a) (b) (c) (d) (e)

PLEASE ANSWER EACH QUESTION FULLY

(15) (a) Was the injured person perfectly sober at the time of accident? (b) under whose direction was he at the time of the accident? (c) was same caused by carrying out such direction?	(a) (b) (c)
(16) (a) Was the injured person suffering at the time of the accident from ill-health, or bodily defect or infirmity of any description? (b) Were you aware of such ill-health, defect or infirmity?	(a) (b)
(17) (a) State fully the nature of the injuries received? (b) State whether such injuries are likely to cause any PERMANENT disablement	(a) (b)
(18) State what extent the injured person is disabled, and whether absolutely prevented from following his employment	
(19) State what you consider will be the probable duration of total disablement	
(20) Give name and address of the injured workman's medical attendant if hospital or nursing home, give name and address	
(21) At what hour on what date was the injury first attended to by a medical practitioner?	
(22) Have you received notification of a Magisterial enquiry? If so, state when and where the same be held	
(23) Has the accident been reported to the labor officer, District commissioner or District officer, if so, where?	

I here by certify that the above statement is full and true account to the best of my knowledge and belief.

Dated this ……..day of …… 19……..……

Employer's Signature…….

CERTIFICATE to be filled up and signed by an Eye witness and if possible by the person under whose direction the workman was at the time of accident.

I hereby certify that I was present when the accident occurred to ……..…….....

On the …… day of ……..….in manner above stated- that it was

Was caused by ……..…….

Which *was/* was not his willful act- and that was not under the influence of intoxicating liquor or drugs at the time.

(signed) Name …….

Address …….

Date …… Occupation ……..

* strike out which is not applicable.