

## WORKMEN'S COMPENSATION CLAIM FORM

N.B. Put a tick  in the appropriate box  where necessary

### INSURED

Name : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_ Tel No : \_\_\_\_\_

Trade/Occupation : \_\_\_\_\_ Policy No. : \_\_\_\_\_

Is there any other Workmen's Compensation Policy in force providing cover for this loss ?  Yes  No  
If yes, please advise :-

Name of Insurer : \_\_\_\_\_

Policy details : \_\_\_\_\_

Number of workers in your employment : \_\_\_\_\_

Number of working days per week :  5 days week  6 days week

### THE INJURED PERSON

Name : \_\_\_\_\_ Age : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_ Tel No. : \_\_\_\_\_

NRIC/Passport No. : \_\_\_\_\_ Occupation : \_\_\_\_\_ Nationality : \_\_\_\_\_

Was the injured person engaged in this occupation when the accident occurred ?  Yes  No

Is the injured person in your direct employment ?  Yes  No

If no, please advise :-

Name of Contractor : \_\_\_\_\_

Address : \_\_\_\_\_

When did the injured person enter your service ? \_\_\_\_\_

Are you satisfied that the injured person sustained injury arising out of and in the course of employment ?  Yes  No

If no, please advise why : \_\_\_\_\_

Was the injured person free from physical defect or infirmity at the time of accident ?  Yes  No

If No, please advise would such physical defect or infirmity contribute towards this accident.  Yes  No

Was the injured person under the influence of intoxicating drink or drugs at the time of accident ?  Yes  No

Was the injured person guilty of any misconduct or disobedience to orders or rules ?

Yes  No

If yes, please give details :

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If the accident was due to machinery or gearing

Please state :-

(i) whether it was fenced or guarded

Yes  No

(ii) was it being cleared whilst in operation ?

Yes  No

Has the accident been reported to the Ministry of Labour (MOL) ?  
(Please attach a clear copy of MOL's report to this form.)

Yes  No

Has the accident been reported to the Police ?  
(Please attach a clear copy of the police report to this form.)

Yes  No

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### THE ACCIDENT

Date : \_\_\_\_\_ Time : \_\_\_\_\_ <sup>a.m.</sup>/<sub>p.m.</sub> Place : \_\_\_\_\_

Give full details of the accident :

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What was the general nature of the contract or work going on ? \_\_\_\_\_

When did you receive notice of accident and from whom ? On \_\_\_\_\_ From \_\_\_\_\_

On what date did the injured person actually cease work ? \_\_\_\_\_

If the injured person has received medical, surgical or hospital treatment :  
Please Advise :-

Name of Clinic/Hospital : \_\_\_\_\_ [ In-patient  Out-patient]

Exact nature of injury : \_\_\_\_\_

Regions affected : \_\_\_\_\_  
(whether left side or right side)

What is the probable period of incapacity ? \_\_\_\_\_ days.



**FATAL CASES** (Additional particulars)

Has the deceased any dependants ?  
If yes, please give particulars below :-

Yes  No

<u>Name</u>	<u>Address</u>	<u>Relationship</u>	<u>Age</u>	<u>Occupation</u>

Will an inquiry into the death be held ?  Yes  No

(a) If yes, please state :- (i) date of inquiry : \_\_\_\_\_  
(ii) place of hearing : \_\_\_\_\_

(b) If no, please forward Death Certificate and Post Mortem Report

**IMPORTANT NOTICE**

1. This form is sent without prejudice to the terms and conditions of the Policy and should not be regarded as a waiver by the Company of any breach of the Policy Conditions which the Insured may have committed.
2. The insured is requested to furnish the particulars above as fully and accurately as possible and this form is to be returned to the Company without delay.
3. All accidents must be reported to the Commissioner for Labour as specified under the Workmen's Compensation Act.

**DECLARATION**

I/We, the undersigned, do hereby, to the best of my/our knowledge, and belief, warrant the truth of all statements herein and the non-concealment or suppression of any material fact, and I/We further agree and undertake that I/ We shall not hereafter make any false statement or conceal or suppress any material fact relating to the accident.

Date \_\_\_\_\_ Signature of Insured \_\_\_\_\_  
(Company's stamp, if applicable)