Report of Accident Form to Workmen

The issue of this form is not to be taken as an admission of liability.
If any detail of information is not readily available please do not delay dispatch of this report. Such particulars may be sent later. All written communications should be forwarded to the Company.

Claim No:……

	THE EMPLOYER		
1	Name of Policyholder		
2	Business		
3	Address		
4	Policy No.		Policy Period: …….. to …….
	THE ACCIDENT		
1.	***DATE:***	***TIME:***	***PLACE:***
2.	Upon what date did you receive notice of accident and from whom? If in writing please attach it to this form		
3.	On what date did the injured/demised person actually cease work?		
4.	State how this accident occurred		
5.	If from machinery (a) Whether it was fenced or guarded (b) Was it being cleaned whilst in motion?		
6.	What was the general nature of the contract or work going on?		
7.	State nature of the injuries/demised & region of injured		
8.	State whether right or left side		
9.	Was the injured/demised person under the influence of alcohol or drugs at the time of the accident		
10.	Was he guilty of any misconduct or disobedience to orders or rules? If so, please give full particulars.		
11.	State through whose neglect it occurred, if any		
12.	State the names of any persons who witnessed the accident		

THE INJURED/DEMISED PERSON		
1	Name:	
2	Age:	Sex:
3	CID / Work Permit No.	
4	Local Address	
5	Permanent Address	
6	State occupation in which the injured/demised person is employed	
7	Was the injured/demised person engaged in this occupation when the accident occurred? If not State fully the nature of the work he was doing at the time of the accident	
8	Is the injured/demised person in your direct employ? If not give name & address of Contractor	
9	When did the injured/demised person enter your service?	
10	Name of hospital taken to	
11	In or out-patient	
12	State whether still in hospital, or discharged, if so when	
13	Has the injured/demised person been medically examined If so, please send report. If not, was free medical examination offered?	
14	State whether returned to work, and if so, when	
15	Are you satisfied that the injured/demised person has met with a bona-fide accident of employment?	
16	Is the injured person able to do partial work?	
17	What is the probable period of the disablement (approximate)?	

The above replies are correct to the best of my / our knowledge and belief.

Date : _____20 ……

Signature of Employer

STATEMENT OF WAGES

The object of this statement is to ascertain the injured person's average ***monthly earnings***. Please therefore observe the following instructions very carefully. Failure to do so will entail unnecessary correspondence and cause undue delay in the settlement of the claim:-

1. If the injured person has been in the service during a continuous period (not broken by an absence of 14 or more consecutive days) of 12 months or more, then enter the wages, etc. paid to him in each month during 12 months immediately preceding the accident.

2. If he has been in the service during a continuous period of less than 12 months but more than a month then enter the wages etc. paid to him in each month during such period immediately preceding the accident.
3. If he has been in the service during a continuous period of less than one month, then enter the wages paid to another workman employed on similar work during 12 months immediately preceding the accident i.e. accident to the workmen in respect of whom the claim is being submitted.
4. If you have no workman employed on similar work and for 12 months then enter the wages etc. paid to the injured workman himself during whatever period of service he has put in immediately preceding the accident.
5. Please specify the period for which wages have been entered in this statement by mentioning the date of the beginning of the period and the end of the period which should be the date prior to the date of accident.
6. Please do not mention merely the rate of wages. Give full details as above.

MONTH	***WAGES***	
	Nu.	***ch.***
TOTAL Nu.		

(a) Were the above stated wages paid, or fallen due for payment, to the injured person If not, State to whom……

(b) Was the injured person absent from work at any time, during the above stated period, for 14 or more consecutive days? ……..
If so, give the following particulars:-
Absent for ……days from ……to ……
Absent for ……days from ……to ……
Absent for ……days from ……to ……
Absent for ……days from ……to ……
Absent for ……days from ……to ……

Date: ……20 **Name & Signature of the Employer**