WORKMEN`S COMPENSATION INSURANCE CLAIM FORM

Claim No ....

Policy No ....

Name of Insured & Address: ....

Name of Injured Employee: ....

Nationality: .... **Age:** .... **Salary:** ....per Month

Description of Accident: ....

....

....

....

Place of Accident: .... **Date:** .... **Time:** .... AM PM

Nature & Extent of Injury: ....

....

Duration of Disablement: ....

Name of other person(s) involved in the accident: ....

Name of witness to the accident: ....

Details of Treatment received and where: ....

....

Has the injured resumed his work after completion of Treatment & the date of resumption: ....

....

Signature /Stamp of the Insured

FOR OFFICE USE			
TTD Period	From:	To:	No. of Days:
TTD Benefits	Amount:	Calculation:	
PPD Benefits	Percentage:	Amount:	Calculation:
Medical Expenses	Amount:		
TOTAL QRs.			