Claim Form

Workers Compensation

REPORT OF INJURY TO AN EMPLOYEE OF……

SECTION A – TO BE COMPLETED BY INJURED WORKER

1. Name…… Male/Female……..….

Address…… Country/State of Origin…..……..……..

Job Classification…… Payroll No……..Age……..

How Employed (at time of accident……..

2. Details of accident: Date…… 20……..Time…….AM/PM

Place of accident (indicate section of project)……..…

……

When did you cease work: Date……. 20……..Time……..AM/PM

3. When did you resume duty: Date……... 20…….Time…….AM/PM

4. Nature and extent of injuries (B.N.: This is worker's assessment…….....

……

5. How were injuries caused?.....

……

6 .Why did accident happen?.....

7. Full name and payroll Nos. of……

Persons who witnessed the accident……..……

……

DO NOT COMPLETE QUESTION 8 IF THIS IS A "NO LOST TIME" CLAIM

8. Are there any persons dependent upon you?.....

Answer "YES" or "NO"

If the answer is "YES" complete "Schedule of dependants"

Schedule Of Dependants

Are you married?..... If so state full name of wife……

Date of marriage……..

Present address of wife…….
(totally)
Is your wife (mainly) dependent on your earnings?*…….
(partially)
(* The worker must write the words totally, mainly or partially as the case may be.)
My children (under 16 years) and all other dependents are:

Name	Relationships	Date of Birth	Place of Residence	Is the person totally, mainly or partially dependent upon your earnings?*

MEDICAL AUTHORITY

I herby authorise any hospital, physician or other person who has attended me, or any employer, to furnish Alpha Insurance Limited or its representatives, any and all information with respect to any sickness or injury, medical history consultation, prescription, or treatment, copies of all hospital or medical records and copies of all records of employees. I agree that a photostatic copy of this authorisation shall be considered as effective and valid as the original.

And I declare that the above particulars are correct and that I have not withheld any information. I agree to notify the employer at once if any of the above-named dependents cease to be dependant upon me or if I do any work whilst receiving compensation or if I change my address.

Signature of injured worker……

Witness…… Date……20…….

SECTION B – TO BE COMPLETED BY EMPLOYERS PAYROLL/PERSONNEL OFFICE –ONLY IF "LOST" TIME

1. Was injured person in direct employment and pay?.....

2. Was he/she employed by a contractor to you?.....When?.....

3. DEPENDANTS (According to official records) Wife?.....

Others…… Number of children…….

4. Number of days and hours worked by him/her per week. Day……..Hours…….

5. Shift time on day of accident – Start…….. a.m./pm. End……..a.m./p.m.

6.

Age last Birthday (if not known state approximately)	How long has he/she been in your employ?	His/her weekly wage before the occurrence of the accident (PLEASE STATE THE CURRENCY)	His/her average weekly earnings for the previous twelve months	If found estimate amount of kee per week

7. Has injured person returned to work? If so, estimate when)……20……

8. If not returned, when expected to do so……..……20……..

9. Where is he/she at present?.....

I/we certify the above information is true and correct to the best of my/our knowledge and belief

Date……20…… Signature of Employer……..……