

Regd. Office: Development House, 24 Park Street, Kolkata – 700 016.

Website: www.magmahdi.com | Toll Free No. 1800-266-3202 | IRDAI Registered No. 149 |

CIN: U66000WB2009PLC136327

UIN - IRDAN149RP0008V02201314

Employees Compensation Claim Form

Claim No.	
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All questions must be answered fully. If there is insufficient space, kindly use a separate sheet which can be attached to this form.

The issue or acceptance of this form is not to be construed as an admission of liability by MHDI.

A. The Insured	Risk Code (For office use)
Name	
Address	
Tel No. Office	Mobile
Email	
Contact name	Mobile
Email	
B. Policy Details	
Policy No	
Period of Insurance//_	to/
C. Injured Person Details	
Name	
Age	
Local Address	
Native place address	
Father's name	
Occupation for which injured was e	employed
Nature/description of job being per	formed by injured person at the time of accident
Is the injured person directly under If not, for whom and in what capac	r your employment Yes No note that injured was working at the time of accident
D. Details of Accident	
Date of accident//	Time of accidentam/pm
Place of accident (exact premises/	
When did you receive intimation of	accident and from whom
How did the accident occur	
Are you satisfied that the accident employment Yes No	occurred in the course of and arising out of



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Was the injured person under the influence of drugs or drinks at the time of accident Yes □ No □						
Was the injured person guilty of misconduct or disobedience of orders/rules						
Yes □ No □						
If yes, provide details						
Names of witnesses						
Is the accident reported to Police or any other authority						
Yes No						
If yes, attach a copy of the report.						
E. Details of Injury & Treatment						
Nature of injury						
Parts/Regions of body affected						
Whether left side or right side						
Name & Address of hospital treated at						
Whether still in hospital or discharged						
What is the medical opinion on nature and extent of disablement						
Whether returned to work Yes No No						
If not, likely date of resumption of duty//						
What is the probable period of disablement						
Declaration						
I/We declare that I/We have not withheld any material information and that all statements made on this form are true to the best of my/our knowledge and belief. I/we understand that the claim may be refused if the information is untrue, inaccurate or concealed.						
Signature of authorized signatory Date						
Company Stamp						



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Documents to be submitted (as relevant to the specific claim) alongwith claim form: FIR

Medical certificate/treatment documents
Fitness Certificate
Death certificate
Post Mortem Certificate
Age proof
Statement of witness
Summons from WC Commissioner
Report to Inspector of Labour
Petition

STATEMENT OF WAGES

The purpose of this statement is to ascertain the injured person's average monthly earnings, hence provide the details carefully and accurately.

Please provide details of injured person's wages for the last 12 months immediately preceding the accident or for shorter period in case employed for less than 12 months. In case he has been employed for less than 1 month, then enter the wages paid to another workman employed for similar work during last 12 months. In case there is no workman engaged in similar work, enter the wages paid to injured workmen himself during whatever period he has been in your employment. If injured person is a daily wager, give the daily rate of wages and average number of days the injured person would have worked in a month.

Month and year (Fill in specific dates for each month)	Wages	Overtime Allowance	Bonus	Value of food subsidy, free quarters, any other allowance	Period of absence
/to					/to



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The above statement of wages is accurate to the best of my/our knowledge and belief.

Signature of	employer.	/authorized	signatory
Company se	eal		

Date

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