

Employees Compensation Claim Form

Claim No. _____

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 employed _____

Nature/description of job being performed by injured person at the time of accident _____

Is the injured person directly under your employment Yes No

If not, for whom and in what capacity the injured was working at the time of accident _____

D. Details of Accident

Date of accident ____/____/____ Time of accident ____ am/pm

Place of accident (exact premises/address) _____

When did you receive intimation of accident and from whom _____

How did the accident occur _____

Are you satisfied that the accident occurred in the course of and arising out of employment Yes No

UIN - IRDAN149RP0008V02201314

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

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



Magma HDI General Insurance Company Limited

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

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

Signature of employer/authorized signatory
Company seal

Date

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