EMPLOYEE'S COMPENSATION INSURANCE CLAIM FORM

ISSUE OF THIS CLAIM FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

Claim Number: _____

Policy Number: _____

Period of Insurance: From _____ To _____

A. DETAILS OF THE INSURED

Name of Insured:

Business:

Address:

City: State: Pin Code:

Phone Number: Mobile Number:

Email Id:

B. DETAILS OF INJURED PERSON

1. Name:
2. Age: yrs. Date of Birth:
3. Sex: M F T
2. Local/Permanent Address:

   City: State: Pin Code:

   Phone Number: Mobile Number:
3. State occupation/nature of work of the injured person:
4. Was the injured person engaged in this occupation when the accident occurred? If not, state exactly the nature of the work he was doing at the time of accident.
5. Is the injured person in your direct employment? If not give name and address of Contractor, under whom employed and nature of work entrusted to contractor.
6. When did the injured person enter your service?
7. Has the injured person been medically examined or hospitalised? If so, please send copy of Medical report.

C. DETAILS OF THE INCIDENT/ACCIDENT

1. Date: Time: hrs.
2. Place:
3. State how this accident occurred:
3. Date of notice of accident and by whom? If in writing please attach it to this form.

4. Time and date when the injured person actually ceased work. Time ☐☐☐☐ hrs. Date ☐☐☐☐☐☐☐☐

5. How long is the disablement expected to last? (Copy of Fitness certificate of attendant doctor to be obtained after returning to work.)

6. Was the accident reported to Police or Inspector of Labour (A copy of report to be attached) Yes ☐ No ☐

7. State nature of injury & part of body affected

8. Was the injured person under the influence of alcohol or drugs at the time of accident? If yes, give details. Yes ☐ No ☐

DECLARATION

I / We the above mentioned, do hereby, to the best of my/our knowledge and belief warrant the truth of the foregoing statement in every respect and I/We have made or in any further declaration the company may require in respect of the said accident shall make any false or fraudulent statement or any suppression or concealment, the policy shall be void and all rights to recover there under in respect of past of future accident shall be forfeited. I/ We also agree to provide additional information to the Company, if required.

Place: ____________________________

Date: ____________________________

____

Signature of Insured

MAGMA
General Insurance Limited

EMPLOYEE'S COMPENSATION INSURANCE CLAIM FORM

STATEMENT OF WAGES

Requirement as per The Employee's Compensation Act.

Please fill in the table of wages below :

Month and year	Basic pay and Dearness Allowance	Overtime Bonus	Concession in value of foodstuffs and others	All others

Total earnings in the period:_____ From: _____ To:_____

Average monthly wages :_____

If the worker's period of service was less than on month, give the average monthly wages of a workman employed on similar work, showing separately Basic Wages, Overtime, Dearness Allowance, Concession in value of food-stuffs, value of free quarters etc.	Basic Wages_____
	Overtime_____
	Dearness Allowance_____
	Concession in value of Food Stuff_____
	Value of Free Quarter (10% of Basic Wages)_____
If the worker was a daily paid employee	Daily rate of wages_____
	Daily Allowances, if any_____
	No. of days on an average that he/she would work in a mon th_____
	Are free quarter provided?_____

The above statement of earnings etc., is accurate to the best of our knowledge and belief.

Place: _____ _____

Date: _____ Signature of Employer

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MEDICAL REPORT

(To be filled up by the Attending Doctor)

1. Name of injured person:

2. Age: 3. Sex: M F T

4. Cause of accident:

5. Nature and extent of injuries:

6. Is the disablement for work : Yes No

   (A) Total or Partial ?

   (B) Solely the result of the Accident? : Yes No

   (C) Was the injured person suffering from any disease or previous injury which may have contributed or aggravated his condition ? : Yes No

7. I certify that he/she has been admitted in the Hospital and in the bed from to and discharged with the following advice.

8. I certify that after discharge he/she requires rest/OPD Treatment as part of the treatment given during Hospitalisation and/or he/she has been under my consultation/advice from to and he/she is fit to join duties w.e.f.

9. I certify that he/she has suffered disability arising out of the said accident and I certify the percentage of disability resulting therefrom @ (As per WC Act Provisions)

10. Was the injured person :-

    (a) Addicted to Alcohol or Drugs Yes No

    (b) Disposed to Malinger Yes No

11. Any Other Remarks

Signature _____

Name of the Doctor _____

Registration No. _____

Date: _____

Hospital _____

SEAL