Householder’s Package Policy (Retail)

Employee’s Compensation Insurance

Claim Form

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Employee's Compensation Insurance

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** □

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 seal :

Documents to be submitted (as relevant to the specific claim) along with 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 ___/___/___

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

Signature of employer/authorized signatory :

Date :

Company Seal :

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