

Employees Compensation Insurance Policy Claim Form

Issuance of this form does not imply acceptance of the liability

Please return the form completed within Fourteen days of the loss together with the relevant vouchers, documents etc.

Policy No.		Claim No.	
Date of Registration			
Area Office Code/Service Centre Code			
Broker/Agent Name		Code	
1. Name of the Insured			
2. Customer ID			
3. Business/Occupation			
4. Address of the Insured			
Plot No./Door No.		Building name	
Road			
Area			
City		Pin Code	
State			
Phone No.			
Aadhaar (UIDAI) No.		PAN No.	
E-mail Id			
Profession/Occupation	☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others		
Monthly Income	☐ Upto ₹ 20,000 ☐ ₹ 20,001 to ₹50,000 ☐ ₹ 50,001 to ₹1,00,000 ☐ ₹ 1,00,000 and above		

5. Details of injured person

a) Name

b) Local/Permanent Address

c) Age/Sex

d) State nature of work for which the injured person was employed

e) Was the injured person engaged in the occupation when the accident occurred?
If not, state exactly nature of work done at that time. ☐ Yes ☐ No

f) Is the injured person in your direct employment? If so, state the date of appointment. ☐ Yes ☐ No

If not, give name and address of Contractor under whom employed and nature of work entrusted to contractor.

[copy of the last voucher obtained from the injured person for the wages paid to be attached.]

g) Under what item of the policy is the injured workman covered?

6. Details of accident

a) Premises at which accident occurred.

b) Exact occupation of the premises and general nature of work done

c) Time and date of occurrence of accident: Date: Time: AM / PM

d) Time when reported and by whom: Time: AM / PM

e) Time and date when the injured person actually ceased work: Date: Time: AM / PM

f) Describe how the accident occurred

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

h) Was the injured person under the influence of alcohol or drugs at the time of accident? ☐ Yes ☐ No

i) Was the injured person guilty of misconduct or disobedience to orders or rules? ☐ Yes ☐ No

j) State whether the accident occurred as a result of negligence on the part of any employee

k) Has the accident been reported to police or inspector of labour? ☐ Yes ☐ No

(A copy of the report to be attached)

7. Details of Loss

a) Describe nature of injury and part of body affected

b) Describe initial treatment offered. If so, When?

State whether admitted in hospital ☐ Yes ☐ No

c) How long is the injured person expected to be in hospital?

d) What is the medical opinion on nature and extent of disablement?

(A copy of the preliminary Medical Report to be attached)

e) How long is the disablement expected to last?

(A copy of the fitness certificate from attendant doctor to be obtained after returning to work)

f) Have you any other insurance covering the workman against WC, Personal Accident, E. S. I. Scheme? ☐ Yes ☐ No
If so, give details.

9. Please give any other particulars relevant to the claim

10. Bank Details

Would you like to opt for NEFT payment?

☐ Yes ☐ No

If YES, please enclose a cancelled cheque leaf along with the claim form.

Bank Name

Branch Name

A/C Holder Name as in Bank Record City State

Account No

IFSC Code

(this is a 11 digit code printed on your cheque leaf)

Declaration by Insured

I/We hereby declare that the statements made by me / us in this claim form are true to the best of my / our knowledge and belief.

Date:

Place:

Signature of Insured/
Authorized Signatory

Statement of Wages

(A) If the injured person has been in the Employer's service during a continuous period of more than one month immediately preceding the accident, then the wages that have been paid, or fallen due for payment to him in each month of such period (not exceeding twelve preceding months in all) must be entered in the statement.

(B) If the injured person has been in the Employer's service for less than one month, the wages paid to another workmen employed on the same kind of work by the Employer, during the twelve months immediately preceding the accident, must be entered in the statement.

(c) If worker is daily paid employee, give

i. daily rate of wages ₹ _____

ii. number of days on an average that he/she works in a month _____

Table of Wages

Please fill in the Table of wages below as applicable to [A],[B] or [C]

Month & Year	Basic Pay & D. A. (₹)	Overtime, Bonus and Dearness Allowance (₹)	Concession value of food-stuff (₹)	Value of free quarters (10% of basic Pay) (₹)	Total (₹)	** ABSENCE
Total						

Total earning in the period

from _____

to _____

Average monthly wages _____

** In column "Absence" give date of going on leave or beginning of period of absence and also of subsequent resumption of work.

The above statement of earnings etc. are, to the best of my knowledge and belief, accurate.

Date: | d | d | m | m | y | y | y | y |

Place: _____

Signature of Insured/
Authorized Signatory

[Add below any additional information available regarding the accident]