(4)

नेशनल इन्श्योरेन्स कम्पनी लिमीटेड

NATIONAL INSURANCE CO. LTD.

O.

CLAIM FORM

Regd. Office : 3, MIDDLETON STREET, CALCUTTA - 700071. CLAIM NO. _____

PARTICULARS OF ACCIDENT TO BE FURNISHED BY THE EMPLOYER B.

These questions are to be answered whether or not a claim from the injured person has been made or is anticipated The Insurer does not admit liability by the issue of this from

NB :- If any detail of information is not readily available PLEASE DO NOT DELAY DESPATCH of this form but send supplementary advices later

PART I - THE EMPLOYER

1. Name of Policy-holder (Employers) ... ...
2. Business ... ...
3. Address (and nearest railway station) ... ...
4. District ... ... 5. Policy No. _____

PART II - THE INJURED PERSON

6. Name of the injured workman ... ...
7. Religion or casts... ... ... 8. Age _____ 9. Sex _____
10. Local address ... ...
11. Mofussil address ... ...
12. Occupation in which injured person is employed ...
13. On what work was injured person engaged at the time of accident occured ? ... ...
14. Was the injured person actually working when the accident occured ?
15. Is injured person in your direct employ ? (if not, give name & address of contractor & nature of contract)
16. Name of Hospital taken to ... ... 17. in or out Patient _____
18. State whether still in Hospital, or when discharged
19. State nature of injury, regions injured and whether left or right ... ...
20. Did injured person actually cease work and if so, on what date ? ... ...
21. Has injured person resumed duty since and if so, on what date ? ... ...
22. What is the probable period of disablement (approximate) ?
23. Was the injured person free from physical infirmity at the time of the accident ? If not, give particulars ...

PART III - THE ACCIDENT

24. Date of accident _____ Time _____ Place _____
25. Did the accident occur actualy within your works premises ? If not where did it occur ?
26. On what date did you receive notice of accident and from whom ? If in writting, please attach to this form ...
27. Are you satisfied that the injured person met with a bonafied accident of employment ? ... ...
28. How exactly did the accident occur ? ... ...
29. If accident due to machinery, state -
    (a) Whether it was fenced or guarded ... ...
    (b) Was it being cleaned whilst in motion ? ...
30. Was injured person under the influence of drink or drugs at the time of the accident ? ... ...
31. Was he guilty or any misconduct or disobediene to orders or rules ? If so, please give full particulars ... ...
32. State through whose neglect, if any, it occured ...
33. State the names of any two persons who withnessed the accident ... ...
34. Give name of overlooker or person in superintendence

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STATEMENT OF INJURED PERSON'S EARNINGS

Statement of wages which have fallen due for payment to _____

_____ in the Employ of _____

_____ for 12 months prior to the date of his accident, or wages earned during such shorter period as he may have been in the employer's service.

Note :- The object of this part of the form is to ascertain the extra average monthly earnings of the injured person. It is essential that it should be carefully and correctly filled in if the injured person has been in service for less than twelve months his date of entry into service is essential. So also if he was absent continuously for more than 14 days (within 12 months) between the date of his entry into service and that of accident, then the period of service should be counted from the date of resumption of duty.

Date on which the injured person first entered service _____ 19

Date on which the injured person resumed duty after a continuous absence of more than 14 days _____ _____ 19

Months and year	Wages earned (including overtime)		Value of bonus, food subsidy, if any, free quarters and any other allowance etc.*		Absences **
	Rs.	P.	Rs.	P.	
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
Total earning in the period from _____					
To _____					

TOTAL INCULDING ALL ALLOWANCES Rs.

MONTHLY AVERAGE WAGE Rs.

SPEICAL NOTICE

If the worker's period of service was less than one month, give the average monthly wage of a workman employed on similar work ..... } Rs. _____

* Please state the exact nature of the allowance and/or bonus.

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

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

Date _____ 19

_____

Signature of employer

(Add below any additional information available regarding the accident.

_____

Signature of employer

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नेशनल इन्श्योरेन्स कम्पनी लिमिटेड
NATIONAL INSURANCE COMPANY LIMITED
SURAT- D.O I

WORKMEN'S COMPENSATION CLAIM FORM

MEDICAL REPORT FORM IN RESPECT OF WORKMEN'S COMPENSATION CLAIMS (TO BE FILLED AND SIGNED BY ATTENDING / TREATING HOSPITAL/ DOCTOR OF INJURED WORKMEN)

(DO NOT KEEP ANY COLUMN BLANK)

CLAIM NUMBER _____ POLICY NUMBER _____

1. Name of the injured person : _____
2. Local Address : _____
   : _____
3. Religion or Caste _____ Age _____
4. Mofussil or Permanent Address : _____
   : _____
5. Occupation : _____
6. Place of Accident : _____
7. Date of Accident : _____
8. Time of Accident : _____
9. Cause of Accident : _____
10. Nature and extent of injuries in detail with exact part of the body affected by the injury, : _____
11. Whether the injured person admitted in a hospital ? : _____
12. If admitted in hospital, Name & address of the treating hosptial of INJURED PERSON : _____
13. Whether admitted as an outdoor patient or an indoor patient or both : _____
14. OPD Case paper number and date : _____
15. IPD Case paper number and date : _____
16. Date of Admission : _____
17. Date of discharge : _____
18. Whether the injured person treated by private doctor ? : _____
19. If so, name & address of treating doctor of the injured person : _____
20. Date of admission/1st treatment : _____
21. Date of Discharge/last treatment : _____

22. Whether screening done ? : _____

23. Whether x-ray of injured part taken : _____

24. If x-ray taken, its reference number & date : _____

25. Is the disablement for work : _____

(a) Total or partial

(b) If the worker has suffered permanent partial disablement. Please state the percentage of loss earning capacity. _____

(c) Solely the result of the accident or partly due to some previous accident or illness _____

26. How long is the disablement likely to continue ? i.e. period of disablement datewise. From _____ To : _____

27. Treatment you adivse or have advised and treatment actually given _____

28. is this being carried out ? : _____

29. Present General Condition of Health : _____

30. Date when fit to resume duty : _____

31. Does the examination point to the injured person being ?

(a) addicted to drink or drugs ? : _____

(b) disposed to malinger ? : _____

32. Remarks _____

(Rubber stamp of treating hopsital/private doctor must be affixed here)

Signature of Medical Officer incharge of Hosptial/Private Doctor : _____

Name _____

Qualification & Designation : _____

Place : _____

Address : _____

Date : _____