IFFCO-TOKIO
GENERAL INSURANCE
The Life You Deserve

IFFCO-TOKIO GENERAL INSURANCE CO. LTD.

H.O. : 'IFFCO Sadan', C-1 Distt. Centre, New Delhi-1100017
CUSTOMER SERVICE CENTRE
301-303, 3rd Floor, Sterling Center, R.C.Dutt Road, Alkapuri, Vadodara-390005
Ph.: 6541600, 6541700 Fax : 0265 - 2356476

W.C. CLAIM FORM

Claim No..... Policy No.....

1 EMPLOYER / INSURED

(A) Name (A)_____

(B) Address (B)_____

(C) Business/Occupation (C)_____

2 **INSURANCES EFFECTED**

Company	Policy No	Full Description of Interest covered	Estimated Amount of wages	Period From	Period To

(If insurance is effected with companies other than IFFCO-Tokio, copies of all policies to be attached)

3 INJURED PERSON

(a) Name (a)_____

(b) Local/Permanent address (b)_____

(c) Age/Sex (c)_____

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

(e) Was the injured person engaged in the occupation when the accident occurred? If not, state exactly nature of work done at that time (e)_____

(f) Is the injured person in your direct employment? If so, State the date of appointment. If not, give name and address of contractor (copy of the last voucher obtained from the injured person for the wages paid to be attached) (f)_____

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

4 **ACCIDENT**

(a) Premises at which accident occurred (a) _____

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

(c) Time and date of occurrence of accident (c) _____

(d) Time when reported and by whom (d) _____

(e) Time and date when the injured person actually ceased work (e) _____

(f) Describe how the accident occurred (f) _____

(g) Are you satisfied that the accident occurred in the course and arising out of employment? (g) _____

(h) Was the injured person under the influence of liquor or drugs at the time accident? (h) _____

(i) Was the injured person guilty of misconduct or disobedience to orders or rules? (i) _____

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

(k) Has the accident been reported to police or inspector of Labour? (A copy of the report to be attached) (k) _____

5 **LOSS**

(a) Describe the nature of injury and part of body affected (a) _____

(b) Describe initial treatment offered. When and whether admitted in hospital? Name of Hospital whether as in patient. (b) _____

(c) How long is the injured person expected to be in hospital. (c) _____

(d) What is the medical opinion on nature and extent of disablement? (A copy o the preliminary Report to be attached) (d) _____

(e) How long is the disablement expected to last? (A copy of fitness certificate of attendant doctor to be obtained after returning to attend duty. (e) _____

(f) Have you any other insurance covering the workman against Personal Accident, E.S.I. Scheme/ If so, give details. (f) _____

I / We hereby declare that the foregoing particulars are true and correct in every respect.

Place:

Date : Signature of Insured

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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 months in all must be entered in the state.

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

(C) If worker is a daily paid employee give (a) daily rate of wages and (b) number of days on an average that he/she would work in a month (a)_____ (b) _____

TABLE OF WAGES

1	2	3	4	5	6
Month & Year	Basic Pay & D.A.	Overtime, Bonus and Dearness Allownace	Concession in value of food-stuffs	Value of free quarters (10% basic wages)	** ABSENCE

Total earnings in the period _____

From _____

To _____

Average monthly wages _____

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

The above statement of earning etc.. is correct to the best of my knowledge and belief.

Place :

Date : Signature of Employer

(Add below any additional information available regarding the accident)