FUTURE GENERALI INDIA
Insurance Co., Ltd.

REPORT OF ACCIDENT TO WORKMAN

Please note that the issue of this claim form is not to be taken as an admission of liability

	DETAILS OF INSURED
1	Name:
2	Address: City Pin Telephone Contact e-mail:

	DETAILS OF INJURED PERSON	
1.	Name:	
2.	Local Address:	
3	Date of Birth / Age	
4.	Address at Native Place:	
5.	Name & Address of Father:	
6.	Details of Occupation in which the injured person is employed	
7.	State fully the nature of work the injured person was doing at the time of the accident	
8.	Is the injured person in your direct employment, If yes, from when? If not, for whom and in what capacity was he working at the time of accident?	
9.	Details of Hospital where insured person was taken? (name , address, tel no, reg.no.)	
10.	Was injured person treated as In or Out-Patient?	
11.	State whether injured person is still in Hospital or discharged, if discharge then pls. give date of discharge	
12.	State whether returned to work and if so, when	

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13.	Are you satisfied that the injured person has met with a bona-fide accident of employment?	
14.	Is the injured person able to do partial work?	
15.	What is the probable period of disablement?	

	DETAILS OF ACCIDENT	
1	Date & time of occurrence	
2	Brief description of accident	
3.	When did you receive notice of accident , who has reported the accident ? (attach statement, if any)	
	On what date did the injured person actually cease work?	
4	What was the general nature of the contract or work going on?	
5	State nature of injury	
6	Was the injured person under the influence of drink or drugs at the time of the accident?	
7	Was he guilty of any misconduct or disobedience to orders or rules? If yes, please give full particulars	
8	State through whose neglect it occurred, if any	
9	State the names of persons who witnessed the accident	
DETAIL OF OTHER INSURANCES		
	Give details of other Insurance, if any, covering the present loss	
DETAILS OF PREVIOUS LOSSES		
	Give details of previous Claims, if any, on the project	

I/We agree that above stated information are correct to the best of my/our knowledge and belief

Date:

Place: Signature of insured with companies seal

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Statement of Wages

Month & Year	Basic pay & D.A	Over time, Bonus and Dearness Allowance	Concession value of food-stuffs	Value of free quarters 10% basic wages	ABSENCE Give Details of leave period and date of subsequent resumption of work
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Total earnings in the period : From: To :
Average monthly wages:

If the worker's period of service was less than one 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……Rs……
()Overtime…… Rs……
()Dearness Allowance…Rs……
() Concession in value
() of food – stuff…. Rs……
() Value of free quarter
(10% of Basic wages) Rs……

If the worker was a daily paid employee, give
(a). daily rate of wages. :Rs.
(b). daily allowances, if any, :Rs.
(c). number of days on an average that he/she would work in a month :……day.
Are free quarter provided?

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

Date : Signature of employer

Note: **The Details Required Are As Per The Workmen's Compensation Act.**

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WC Medical Report

1. Name of injured person: _____

2. Age and Date of Birth _____ **3.** Sex: _____

4. Cause of injury: _____

_____

5. Full description of the nature ad extent of injuries: _____

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6. Date and time of first consultation: _____

7. Investigations done and observations: _____

_____

_____

8. Does the cause of accident as stated by claimant tally with the injuries noticed: YES/NO _____

9. Are the injuries solely due to the result of the said accident: YES/NO _____

10. Was the injured person suffering from any disease or injury which may have contributed or aggravated his condition: YES/NO _____

11. I/We certify that he has been admitted in the Hospital _____ and in the bed from _____ to _____ and discharged with the following medical advice:

_____

_____

_____

12. I/We certify that after discharge he requires rest/OPD Treatment as part of the treatment given during Hospitalization and/OR he has been under my consultation/advice from _____ to _____.

He is fit to join duties w.e.f. _____.

13. I/We certify that the he has suffered disability arising out of the said accident, the nature and extent of the disability is as under :

_____

_____

_____

I/We certify the % of disability @ _____ (as per WC Act Provisions).

14. Was the injured person:

- Under influence of Alcohol:
- Disposed to malinger:

15. Other Remarks:

_____

Date: _____

Signature: _____

Name of the Doctor: _____

Reg. No.: _____

Name of Hospital: _____