

# Work Injury Compensation Insurance Claim Form

Company: \_\_\_\_\_ Contact No.: \_\_\_\_\_ Email address: \_\_\_\_\_

1. Full the particulars of the accident as to be furnished by the employer described in this form.
2. The giving of the undermentioned information does not imply that the injured person is making, or will make claim.
3. The form is sent without prejudice to the terms of the policy described in this form.
4. This form is to be completed and forwarded without delay. Any details of information not really available may be supplied as soon as obtainable.
5. all written communications received by the employer concerning the accident to its employee should be forwarded at once to Capital Star Insurance (Company).

## THE EMPLOYER

Name of Policyholder: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Business: \_\_\_\_\_ Contact No.: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

## THE INJURED PERSON

Name: \_\_\_\_\_ Nationality: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Local Address: \_\_\_\_\_

When did the injured person enter your services? \_\_\_\_\_

Work in which the injured person is usually employed: \_\_\_\_\_

Was the injured person engaged in the above work when the accident occurred? \_\_\_\_\_

Is the injured person, direct employee, contractor's employee or a sub-contractor? \_\_\_\_\_

Name of hospital taken to: \_\_\_\_\_ In or out-patient: \_\_\_\_\_

State whether still in hospital taken to: \_\_\_\_\_

Has the injured person been medically examined? If so, please send report. If not, was free medical examination offered?  
\_\_\_\_\_

State whether returned to work, and if so, when? \_\_\_\_\_

The injured worker works a five or five- and half-day week or ultimate Thursday: \_\_\_\_\_

Are you satisfied the injured person has met with real accident arising out of his/her employment? \_\_\_\_\_

Is the injured person able to do partial work? \_\_\_\_\_

What is the probable period of disablement (approximate)? \_\_\_\_\_

**THE ACCIDENT**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Place: \_\_\_\_\_

On what date did you receive notice of accident and from whom? If in writing, please attach to this form: \_\_\_\_\_

On what date did the injured person actually cease work? \_\_\_\_\_

Briefly describe what was the cause of the accident and how it happened.

\_\_\_\_\_  
\_\_\_\_\_

Briefly describe the nature of injury sustained.

\_\_\_\_\_  
\_\_\_\_\_

What was the general nature of the contract or work going on? \_\_\_\_\_

Where amputation is involved, please state precisely at which phalanx/part was amputated and state left or right side.

\_\_\_\_\_

Was the injured person under the influence of drink or drugs at the time of the accident? \_\_\_\_\_

Was he/she guilty of any mis conduct or disobedience to orders or rules? If so, please give full particulars.

\_\_\_\_\_

State through whose neglect the accident occurred, if any: \_\_\_\_\_

State the name of any persons who witnessed the accident: \_\_\_\_\_

Has the accident been reported to the Police? State when and where

\_\_\_\_\_

Additional particulars for FATAL CASES only

Has the deceased any dependents? State names, addresses and relationship

\_\_\_\_\_  
\_\_\_\_\_

Will an enquiry into the death be held? If so, please supply a copy of the notes as soon as possible. \_\_\_\_\_

If no enquiry will be held, a Medical or the Post Mortem Certificate is required. \_\_\_\_\_

Statement of wages of the Injured Person earned IN THE PRESENT EMPLOYMENT for twelve months immediately prior to the date of this Accident, or wages earned during such shorter period as he/she may have been in the Employer's service, stating the date on which he/she was engaged.

