INSURER: ----------

WORKMEN COMPENSATION CLAIMS FORM

CLAIM NO: …… POLICY NO: ……

I/We give you hereunder particulars of an accident to one of our workmen, and shall be glad to furnish any further information you may require

EMPLOYER'S SIGNATURE: ……

TRADE OR BUSINESS: ……

ADDRESS: ……

DATE: ……

DETAILS OF UNJUED WORKMAN

1.	(a)	Full Name	(a)
	(b)	Address	(b)
	(c)	Occupation and Age	(c)
	(d)	State if married and number of Children	(d)
	(e)	Amount of weekly earnings	(e)
	(f)	He is in direct employment of	(f)
	(g)	How long has he worked for you	(g)

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2. The accident happed at a.m/pm on the day of 20 at

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3. The injured workman ceased work on the day of 20

4. The accident happed thus (N.B. Please give fullest possible description, stating particularly if caused by machinery, or by the fault of any person in the latter case give name of person and state by whom employed)

5. The workman sustained the following injury or has contracted the following disease

6. The names and addresses of witnesses are:-
   (1) ……
   (2) ……
   (3) ……
   (4) ……

IMPORTANT: IN THE EVENT OF THE ACCIDENT RESULTING IN DEATH, IMMEDIATE NOTICE MUST BE GIVEN TO THE COMPANY BY EMAIL OR TELEPHONE.