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WORKMEN'S COMPENSATION CLAIM FORM

POLICY NO: …….……

Employer/Insured: ……..

Postal Address: ……Email Address:……..

Business: …… Date: ……..

1. DETAILS OF INSURED WORKMAN	
a. Full Name	a …….
b. Address	b ……...
c. Occupation and Age	c. ……...
d. Amount of weekly Earnings	d …….
e. How long has he/she worked for you?	e……

2. The accident happened at…….....am/pm on the……day of……

at (place)…….

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

4. Give details on how the Accident happened: ……

……

……..

……..

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

6. The workman and address of the witnesses are1. ……	2……..
	3……..
	4……...

Date: …… ……..

Insured's Signature and stamp