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GEMINIA INSURANCE CO.LTD.

WORKMEN'S COMPENSATION INSURANCE CLAIM FORM

INSTRUCTIONS:

- Please read carefully and fill out the entire form.
- All questions must be answered in full, in BLOCK letters in the applicants own handwriting or dictation

EMPLOYER

I. Name of Employer_____ Full Address_____

2. State

(a) Name & Policy_____

(b) Date of last payment of premium_____

3. Nature of Trade or Business_____

INJURED WORKMAN

4. Name_____ Full address_____
(in the case of Africans give particulars of Tribes. Village. District)

5. Occupation _____ Age_____ Sex_____

Married or single _____ Tax or identity number_____

6. Is the injured Employee related to the Employer?_____
(what is the relationship'?)

7. Was he/she in your direct employment or in that of a Sub-Contractor? ☐ Yes ☐ No

8. If in your employments how long has he/she been so?_____

9. Give rate of pay PER MONTH at the thee of Accident_____

10. In addition to wages state the MONTLY cash value of any allowances or perquisites i.e. food.fuel, quarters, cost of living or other special remuneration, If of a constant character. if any. are granted?

_____

11. State FULLY the nature of the work he was doing at the time of the Accident_____

12. How did the Accident occur?_____

13. Where did the Accident occur?_____ District_____

14. a) When did the accident occur? at_____m on the_____day of_____ 20_____

b) When did the injured employee cease work on account of accident? at_____m on the_____day of_____ 20_____

15. Was the Accident caused

(a) Violation of rules?_____

(b) Carelessness of Injured workman?_____

(c) Carelessness of any other person?_____

If so who?_____

(d) Any defect of machinery or plant?_____

(e) Had such defect been brought to your Notice?_____

16. (a) Was the injured person perfectly sober at the time of accident?_____

(b) Under whose direction was he at the time of the Accident?_____

(c) Was same caused by carrying out such direction?_____

17. (a) Was the injured person suffering at the time of the Accident from ill-health or bodily defect or in firmity of any description'? ☐ Yes ☐ No

(b) Were you aware of such ill-health. defect or infirmity? ☐ Yes ☐ No

18. (a) State fully the nature of the injuries received_____

(b) Data whether such injuries are likely to cause a, PERMANENT disablement_____

19. State to.what extent the injured person is disabled, and whether absolutely prevented from following his employment

_____

20. State what you consider will he Is probable duration of total disablement_____

21. Give name and address of the injured workman's medical attendant. If in hospital or nursing home, give name and address

_____

22. At what hour on what data was the injury first attended to by a medical practitioner?_____

23. Have you received notification of a magisterial inquiry? ☐ Yes ☐ No

If so, state when and where the same to be held_____

24. Has the accident been reported to the labour office, district commissioner or district officer, if so, where?

_____

I hereby certify that the above statement is a full and true account to the best of my knowledge and belief

Date this _____day of_____20_____

I hereby certify that the above statement is a full and true account to the best of my knowledge and belief

Employer's Signature_____

CERTIFICATE to be filled up and signed by an Eye Witness and if possible by the person tinth.o whose direction the Workman was at the time of the Accident

I hereby Certify that I was present when the Accident occurred to_____

which was/was not his/her wilful act - and that he/she was not under the influence of intoxication liquor or drugs at the time

(Signed) Name_____

Address _____Date_____ Occupation_____

on the_____day of_____ in manner above stated - that it was

caused by_____

which was/was not his/her wilful act - and that he/she was not under the influence of intoxication liquor or drugs at the time

(Signed) Name_____

Address_____Date_____ Occupation_____

*strike out which is not applicable