EMPLOYERS' LIABILITY CLAIM FORM

Policy no _____

Particulars of accident to be furnished by the Employer

These questions are to be answered whether or not a claim from the injured person has been made or is anticipated. The insurer does not admit liability by the issue of this Claim Form. P.S. – If any details of information are not readily available PLEASE DO NOT DELAY DESPATCH of this form but send supplementary advices later.

PART - I: THE EMPLOYER	
NAME OF POLICY HOLDER:	
BUSINESS:	
ADDRESS: DISTRICT:	

PART II - THE INJURED PERSON	
NAME:	
RELIGION OR CASTE:	
AGE:	
SEX:	
LOCAL ADDRESS:	
OCUPATION IN WHICH INIURED IS EMPLOYED:	
ON WHAT WORK WAS THE INJURED PERSON ENGAGED AT THE TIME OF ACCIDENT?	
WAS THE INJURED ACTUALLY WORKING AT THE TIME OF ACCIDENT?	
IS THE INJURED PERSON IN YOUR DIRECT EMPLOY?	
IF NOT GIVE NAME AND ADDRESS OF CONTRACTOR AND NATURE OF CONTRACT:	

NAME OF THE HOSPITAL TAKEN TO:	
STATE WHETHER STILL IN HOSPITAL OR DISCHARGED?	
STATE NATURE OF INJURY:	
DID INJURED PERSON ACTUALLY CEASE WORK AND IF SO ON WHAT DATE?	
HAS INJURED PERSON RESUMED DUTY SINCE AND IF SO ON WHAT DATE?	
WHAT IS THE PROBABALE PERIOD OF DISABLEMENT?	

PART III: THE ACCIDENT	
DATE OF ACCIDENT:	TIME: PLACE:
DID THE ACCIDENT OCCUR ACTUALLY WITHIN YOUR WORK PREMISES, IF NOT WHERE DID IT HAPPEN?	
ON WHAT DATE DID YOU RECEIVE NOTICE OF ACCIDENT AND FROM WHOM, IF IN WRITING PLEASE ATTACH TO THIS FORM?	
HOW EXACTLY DID THE ACCIDENT OCCUR?	
IF THE ACCIDENT DUE TO MACHINERY STATE WHETHER FENCED OR NOT:	
WAS THE INJURED PERSON UNDER THE INFUENCE :OF DRINKS OR DRUGS AT THE TIME OF ACCIDENT?	
GIVE NAME OF THE SUPERVISOR:	

The above replies are true to the best of our knowledge and belief.

Place:_____ Signature _____

Date:_____ Name & Designation:_____

STATEMENT OF INJURED PERSON'S EARNING

Statement of wages fallen due to payment to _____ in the employ of_____ for 12 months prior to the date of his accident or wages earned during such shorter period as he may have been in the employer service.

Note: The object of this part of form is to ascertain the extra average monthly earning of the injured person. It is essential that it should carefully and correctly filled in, if the injured person has been in service less than twelve months his dated of entry into service is essential so also if he was absent continuously for more than 14 days (within 12 months) between the date of his entry into service and that of accident then the period of service should be counted from the date of resumption of duty.

Date on which the injured person first entered service _____

Date on which the injured person resumed duty after a continuos absence of more than 14 days _____

Month and year	**Wages earned (Including overtime)**	**Value of bonus, food subsidy, if any free quarter and any other allowance etc.**	**Absences**
	Rs	**Rs**	
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
Total earning in the period			

Total Including all Allowance Rs _____

SPECIAL NOTICE

If the workers period of service was less than one month give the} Rs
average monthly wages a workman employed on similar work

* Please state the exact nature of the allowance and or bonus.
* In column absences give date of going on leave or beginning of the period of absence and also date of subsequent resumption of work.

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

Date: Signature of Employer