

Reliance Insurance Company Limited 181-A, Sindhi Muslim Co-operative Housing Society, Karachi Tel: 92-21-3-4539415-17 Fax: 92-21-3-4539412 Email: claim@relianceins.com

H.O

WORKMAN COMPENSATION CLAIM FORM

Claim Form	B.O.						
PARTICULARS OF ACCIDENT TO BE FURNISHED BY THE EMPLOYER The questions are to be answered whatever or not claim from the injured person has been made or is anticipated. The insurer does not admit liability by the issue of this form.							
N.B. If any detail of information not readily available PLEASE DC advice later	NOT DELAY DESPATCH of this form but send supple mentary						
PART 1 – THE EMPLOYER							
Name of Policy holder							
2. Business							
Address (and nearest railway station) District	5. Policy No						
PART II - THE INJURED PERSON							
6. Name 7. Religion or Caste	8. Age 9. Sex						
10. Local Address							
11. Mofussil Address12. Occupation in which injured person is employed.							
13. On what exact work was injured person engaged at time of accident?							
14. Was injured person actually working when accident occurred?							
(a) is injured person in your direct employee?(b) If not given name and address of contractor and							
Nature of contract							
46 37 01 111							
Name of hospital taken to State whether still in hospital or when discharged							
19. State nature of injury, regions injured and whether	17. In or out patient						
Left or right							
Did injured person actually cease work after Accident and if so on what date?							
21. Has injured person resumed duty since and of so on what date							
22. What is the probable period of disablement							
(approximate) 23. Was injured person free from physical infirmity at							
Time of accident? If not give particulars							
PART - III - THE ACCII							
24. Date of accident: 25. Did accident occur actually within your works	Time Place						
Premises? If not where did it occur?							
26. (a) On what date did injured person report accident							
(b) To whom was report made. 27. Are you satisfied injured person met with a							
Bonafide accident of employment?							
28. How exactly did the accident occur? (give full details)							
(give full details)							
29. If accident due to machinery state:-							
(a) whether it was tenced or guarded(b) was it being cleaned whilst in motion?							
30. Was injured person under the influence of drink or							
Drugs at time of accident? 31. Was injured person guilty of any misconduct or							
31. Was injured person guilty of any misconduct or Disobedience to orders or rules? If so please give							
Full particulars							
32. State through whose neglect, if any, it occurred 33. Statement of any two persons who witnessed the							
Accident.							
34. Give name of overlooker or person in							
superintendence The above replies are accurate to the best of my known to the best of the	nowledge and helief						
The above replies are accurate to the best of my ki	io wieuge und oellet.						
Date20	Construe of Familiaria						
(Please use reverse of form for any further information or attach a so	Signature of Employer eparate report) P.T.O.						



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STATEMENT OF INJURED PERSONS EARNINGS

Statement of wages which have fa					
				f the accident, wa	ages earned during such
shorter period as the injured person n NOTE:-	nay have been in th	ie employer's se	ervice.		
	ascertain the exact	average monthl	v earnings of t	he injured person	It is essential during the above
period of employment, state		-	y carmings of t	ne injured person.	it is essential daring the above
r · · · · · · · · · · · · · · · · · · ·	.				
Date on which worker com	imenced duties for	the last period	of service		
Before					
		Wages earned (including		quarters and any	
MONTHS AND VEAD		overtime: bonus and all cash		ce	ABSENCE
MONTHS AND YEAR	payments)				
	Rs.	Ps	Rs.	Ps.	
1.					
2.					
3.					
4. 5.					
6.					
7.					
8.					
9.					
10.					
11. Total earnings in the period from					
to Total Rs					
	L	l			1
Total Incl	uding all allowance	es Rs.			
Average N	Monthly Wages	Rs.			
_					
	SPECIAL NOTES				
If the worker's period of service was			D		
average monthly wages of a workma	in employed on sin	nılar work.	Rs		
if worker was a daily paid employee	aire (a) dailr rata	of words (b) nu	mbor of days o	n an arranga that h	a/aha work in a month
ii worker was a dairy paid employee	give (a) daily rate (of wages (b) flui	a)	ıı alı average tilat il	
			b)		
			0)		
State the exact/nature of allow	owance	Are fre	e quarters prov	rided?	
State the exact/nature of allowIn column "Absence" give of	late of going on lea	ve or beginning	of period of a	bsence and also da	te of subsequent resumption
of work.	2 2				1
The above statement	nt of earnings, etc t	to the best of my	knowledge ar	nd belief accurate.	
					<u>-</u>
		(A 11 L .1 -	1	Signature of E	
		(Add below an	y additional in	iormation available	e regarding the accident)
Date 20					
				Signature of E	mployer
					1 ·