SHRIRAM GENERAL INSURANCE
be insured.... rest assured

Workmen Compensation Claim Form

The issue of this form is not an admission of liability. Please fill in all columns of the claim form. Attach Separate Sheet if the space is not sufficient.

Policy Number :		Valid Up to :
Insured		
1.	Name of the Policyholder :	
2.	Business :	
3.	Address :	
4.	Contact Number:	Landline: Mobile:
5.	E-mail:	
Injured Person		
1.	Name:	
2.	Address:	
4.	Name & Address of Father:	
5.	Occupation in which the injured person is employed	
7.	State fully the nature of work, the injured person was doing at the time of the accident	

8.	Is the injured person in your direct employment?	
9.	If yes, when did the injured person join your service?	
	If not, for whom and in what capacity was he working at the time of accident?	
10.	Name of Hospital taken to:	
	Address:	
11.	Was he treated as in or out-patient?	
12.	State whether still in Hospital or discharged (if already discharged, please mention date of discharge)	
13.	Has the injured person been medically examined? If yes, please attach report	
	If not, why was no medical examination offered?	
14.	State whether returned to work and if so, when	
15.	Is the injured person able to do partial work?	
1.	**Accident** (a) Date & Time of accident : (b) Place of accident :	
2.	When did you receive notice of accident and from whom? If in writing, please attach it to this form	
3.	On what date did the injured person actually ceased working?	
4.	State how this accident occurred	
5.	If from machinery: a) Whether it was fenced or guarded	
	b) Was it being cleaned whilst in motion?	
6.	What was the general nature of the contract or work going on?	

7.	State nature of injury	
8.	State body part injury	
9.	State whether right or left side	
10.	Was the injured person under the influence of drink or drugs at the time of the accident?	
11.	Was he guilty of any misconduct or disobedience to orders or rules? If so, please give full particulars	
12.	State through whose neglect it occurred, if any	
13.	State the names of persons who witnessed the accident	

I, undersigned confirm that the above given details are true & correct to the best of my/ our knowledge.

Place:

Date: Signature of Insured

STATEMENT OF WAGES

The object of this statement is to ascertain the injured person's average monthly earnings. Please therefore observe the following instructions very carefully.

1. If the injured person has been in the service during a continuous period (not broken by an absence of 14 or more consecutive days) of 12 months or more, then enter the wages, etc; paid to him in each month during 12 months immediately preceding the accident.
2. If he has been in the service during a continuous period of not less than 12 months but more than a month, then enter the wages, etc; paid to him in each month during such period immediately preceding the month.
3. If he has been in the service during a continuous period of less than 1 month, then enter the wages paid to another workman employed on similar work during 12 months immediately preceding the accident i.e. accident to the workman in respect of whom the claim is being submitted.
4. If you have no workman employed on similar work, then enter the wages, etc; paid to the injured workman himself during whatever period of service he has put in immediately preceding the accident.
5. Please specify the period for which wages have been entered in this Statement by mentioning the date of the beginning of the period and the end of the period, which should be the date prior to the accident.
6. Please do not mention merely the rate of wages. Give full details as above.

Month	Wages		Bonus , Value of Free quarters, any other allowances	
	Rs.	Np.	Rs.	Np.
Total				
	Total including all allowances			

(a) Were the above stated wages paid or fallen due for payment, to the injured person? If not, state to whom.

(b) Was the injured person absent from work at any time during the above stated period, for 14 or more consecutive days? If yes, give the following particulars:

Absent for days from to

Absent for days from to

Absent for days from to

Absent for days from to

Date: Place: Signature of the Employer