SURAKSHA AUR BHAROSA DONO

(A joint venture between of State Bank of India and Insurance Australia Group)

Corporate & Registered Office: Fulcrum Building, 9th Floor, A & B Wing, Sahar Road, Andheri (East), Mumbai 400 099.

CLAIM FORM - WORKMENS COMPENSATION

ISSUE OF THIS CLAIM FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

Policy Number_____ Period of Insurance _____ to _____

Claim Number_____

A. DETAILS OF INSURED/CLAIMANT:

Name of the Insured : _____

Address _____

City_____State_____Pin Code_____

Phone Number : _____ Mobile Number _____ Email ID_____

Business/Occupation _____Period of Insurance From ____/____/_____ to ____/____/_____

Limits of Indemnity under the policy _____

B. DETAILS OF ACCIDENT:

Date of Accident _____/_____/_____ Time of Accident _____A.M. / P.M.

Cause of Accident / Incidence : _____

Address line 1 : _____

Address line 2:_____

City_____State_____Pin Code_____

Phone Number : _____ Mobile Number _____ Email ID_____

WITNESS DETAILS	INFORMATION TO AUTHORITY
Were there any witnesses to the Accident and resultant injuries/death ? ☐(Yes) ☐(No), If 'Yes', Name of Person/s_____ Address _____ _____ City_____ State_____ Pin Code_____ Phone Number _____	Has the Accident been reported to an Authority ☐ (Yes) ☐(No), Name of Authority _____ Authority Reference No. _____ Contact Person/s_____ Address _____ _____ City _____State_____ Pin Code_____ Phone Number _____

Mobile Number_____	Mobile Number_____
Email ID _____	Email ID _____

C. DETAILS OF OTHER INSURANCE/INTEREST

Is the Accident/damage covered under any other Insurance ☐ (Yes) ☐(No), If 'Yes', specify details and attach a copy of the policy

Name of Insurer: _____

Address _____

City_____State_____PinCode_____

Phone Number _____MobileNumber_____EmailID_____

Policy No._____ Period of Insurance _____to_____

Sum Insured (Rs.)_____

THE INJURED / DECEASED PERSON Name and address of Injured/deceased :

_____

Gender: ☐ (Male) ☐(Female), Date of birth / Age: _____

Address _____

City_____State_____PinCode_____

Phone Number _____ Mobile Number_____

State occupation / nature of work of the injured person _____

Was the Injured/deceased person engaged in this occupation when the accident occurred? _____

If "No", state exactly the nature of the work he/she_____

was doing at the time of accident. _____

If the Injured/deceased person in your direct employment?

If "No", give details

Name of the Contractor _____

Address Line 1 _____

Address Line 2 _____

Phone Number _____ Mobile Number _____

City_____State_____PinCode_____

Nature of work entrusted to contractor _____

When did the Injured/deceased person enter your service? _____/_____/_____

Have the Injured/deceased persons been taken to hospital or medically attended? If "Yes", specify

☐ (Yes) ☐(No),

Name of Hospital / Physician _____

Date of Admission ____/____/_____ Date of Discharge ____/____/_____

Address Line 1 _____ Address Line 2 _____

Phone Number _____ Mobile Number _____

City_____State_____PinCode_____

D. INJURY DETAILS

State nature of injury & part of body affected _____

Is there disablement? ☐ (Yes) ☐(No),

If "Yes" select ☐Total ☐ Partial ☐ Permanent ☐ Temporary

Is the disability solely caused by this accident / Incident ☐ (Yes) ☐(No),

If "No", give details _____

How long is the disablement expected to last? _____ Days Upto ____/_____/_____

Extent of disability _____%

Is any improvement possible from current disablement? _____ ☐ (Yes) ☐(No),

If "Yes" specify with % improvement and action required _____

Time and date when the injured person actually ceased work.

Date _____/_____/_____ Time _____: _____AM / PM

Was the injured person under the influence of alcohol or drugs at the time of accident? ☐ (Yes) ☐(No),

Present health condition _____

Death examination point of ☐ Addiction to drugs / alcohol ☐ Disposed to Malinger

Any other details _____

Post Mortem Done ☐ (Yes) ☐(No), Date of PM Done ____/____/_____ PM No. _____

Name of Hospital where Post mortem has been done _____

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or make in any further declaration, the Company may require in respect of the said accident, any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void, and all rights to recover there under in respect of past or future Accident/accident shall be forfeited.

Place: Signature:

Date: Name of Insured/Claimant:

E. INJURY DETAILS

The object of the statement is to ascertain the injured person's average monthly earnings. Please therefore observe the following instructions very carefully. Failure to do so will entail unnecessary correspondence and cause undue delay in the settlement of the claim:-

1. If the injured person has been in the service during a continues period (not broken by an absence of 14 or more, then enter the wages paid to him in each month during 12 months immediately preceding the accident.
2. If he has been in the service during a continues period of less than one month, then enter the wages paid to another workmen employed on similar work during 12 months immediately preceding the accident.

3. In all other cases, the monthly wages shall be the average daily earnings (Amount of wages/Actual number of days worked) multiplied by 30.

F. TABLE OF WAGES

Please fill in the table of wages below as applicable to 1, 2 or 3 above.

Month and Year	Basic pay and dearness Allowance	Overtime bonus	Concession in value of food – stuffs and others	All others

Total earnings in the period (specify dates) _____ Average monthly wages _____

Were the above stated wages paid, or fallen due for payment, to the injured person? ☐ (Yes) ☐(No),

Was the injured person absent from work at any time, during the above stated period, for 14 or more consecutive days? ☐ (Yes) ☐(No),

If "Yes", period of absence from ____/____/_____ to ____/____/_____

Reasons for absence _____

The above statement of earnings is accurate to the best of our knowledge and belief.

Place: Signature:

Date: Name of the Insured:

Suggested Documents for Settlement of Claim

The following are the some of the elementary documentation required for the processing/determining the liability of the company for claims reported by the Insured. However, please note that the documentation mentioned hereunder is only indicative in nature and further documentation required by the Company will be sought, if required.

Basic Documents Required:

General for all type of claims:

- Claim Form duly filled in & signed.
- Claim Bill.

Temporary Disablement Claims:

- Medical Certificate regarding Cause & Duration of Disablement.
- Medical Bills.

Permanent Disablement Claims:

- Medical Certificate regarding Disablement.
- Memorandum of Agreement as per W.C Act between Insured and the injured workman.

Fatal Claims:

-
- Death certificate.
- Copy of post Mortem report.
- F.I.R / Final Investigation report?
- Form A of W.C Act duly completed by the Insured.
- Statement of Witnesses, if any?