



**NOTIFICATION OF INJURY TO AN EMPLOYEE**

This form is to be filled up and sent to the Company immediately the accident comes to the Employer's knowledge.

**WIBA CLAIM FORM**

<b><u>EMPLOYER:</u></b>	
(1) Name or style of Employer and full address (2) Email addresses.	
(2) State (a) No. of policy (b) Date of last payment of premium	
(3) Nature of Trade Business.	
<b><u>INJURED EMPLOYEE</u></b>	
(4) Name of full address	
(5) (a) Occupation? _____ (b) Age? _____ (c) Married or single? _____	
(6) Is the injured Employee related to the employer? If so, what is relationship?	
(7) Was the injured workman in the employ of the Insured or in the employ of a contractor? If the latter. Name and address of the Contractor and nature of contract	
(8) Was the injured workmen's employment Casual or regular? If the former, state how often employed If the latter, state how long he had been employed by you or such Contractor prior to the Accident	
(9) (a) Give rate of pay at time of Accident. (state whether per day, or month) (b) State value of food and for housing per month	
(10) If apprentice, learner or improver, state his terms of remuneration to end of apprenticeship and how he might then expect to earn.....	
(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?	
(14) When did the Accident occur?	HOUR AT _____ M on the ----- day of -----20
(15) Give names and address of witness of the Accident	
(16) Was the accident caused by:----- (a) Violation of rules? (b) Carelessness of injured Employee? (c) Any defect of machinery or plant? If so, had such been brought to your notice?	

(17) Was the injured person sober at time of the Accident? Under whose direction was he at the time of the Accident?  Was the Accident caused by carrying out such direction?	
(18) Was the injured person suffering at The time of the Accident from ill-Health or bodily defect or infirmity of any description?	
(19) Were you aware of such ill-health, defect or infirmity?	
(20) Has the injured person previously received compensation for an Accident sustained either whilst in your service or in that of a previous employer? If so, please state: (a) The date of the Accident (b) The amount of the compensation received	
<b>(21) State as fully as possible the nature of the injury received.</b>	
(22) State to what extent the injured is disabled and whether absolutely prevented from following his employment	
<b>(23) State what you consider will the probable duration of total disablement.</b> NOTE:- It is important that the fullest possible information be given under this head.	
(24) Give name and address of the Injured workmen's Medical Attendant If Hospital, give name of same.	
(25) At what hour and on what date Was the injured first attended to by a Doctor?	
(26) Have you received notification of a Magisterial Enquiry, or of intention to institute any legal proceeding? If so, give full particulars.	

I/ WE hereby certify that the above Statement is a full and true account to the best of my /our knowledge and belief, and I/WE undertake to advise the Company promptly of all development in connection with the claim.

Date this-----Day of -----

Employer's Signature-----

Note to Employer: - It is a condition of your policy that payment must be made, nor any liability admitted, in respect of Accidental injury to an Employee, until ordered by Court, or authorised by the Company.

**Certificate to be filled up and signed by an Eye Witness, if possible by the person under whose direction the Workman was at the time of the Accident.**

I hereby certify that I was present when the accident occurred to-----on the-----day of -----and that happened in the following manner:-

Signature-----

Occupation-----

Date-----