HOUSEHOLDER'S PACKAGE POLICY (RETAIL)

Employee's Compensation Insurance Claim Form

MAGMA
General Insurance Limited

Employee's Compensation Insurance

Claim Form

Claim No._____

All questions must be answered fully. If there is insufficient space, kindly use a separate sheet which can be attached to this form.

The issue or acceptance of this form is not to be construed as an admission of liability by Magma General Insurance.

A. The Insured Risk Code (For office use)

Name : _____

Address :_____

Tel No. Office : _____ Mobile : _____

email : _____

Contact name : _____ Mobile : _____

email _____

B. Policy Details

Policy No. _____ Period of Insurance ____/____/_____ to _____/_____/_____

C. Injured Person Details

Name : _____

Age : _____

Local Address : _____

Native place address : _____
_____

Father's name : _____

Occupation for which injured was employed : _____

Nature/description of job being performed by injured person at the time of accident : _____
_____

Is the injured person directly under your employment : Yes □ No □

If not, for whom and in what capacity the injured was working at the time of accident : ____
_____

D. Details of Accident

Date of accident : _____/_____/_____ Time of accident : _____am/pm

Place of accident (exact premises/address) : _____

When did you receive intimation of accident and from whom : _____

How did the accident occur : _____

Are you satisfied that the accident occurred in the course of and arising out of employment?

Yes ☐ **No** ☐

Was the injured person under the influence of drugs or drinks at the time of accident ?

Yes ☐ **No** ☐

Was the injured person guilty of misconduct or disobedience of orders/rules

Yes ☐ **No** ☐
If yes, provide details; _____

Names of witnesses : _____

Is the accident reported to Police or any other authority : **Yes** ☐ **No** ☐
If yes, attach a copy of the report.

E. Details of Injury & Treatment

Nature of injury : _____
_____

Parts/Regions of body affected : _____

Whether left side or right side : _____

Name & Address of hospital treated at : _____
_____

Whether still in hospital or discharged : _____

What is the medical opinion on nature and extent of disablement : _____
_____

Whether returned to work : **Yes** ☐ **No** ☐

If not, likely date of resumption of duty _____/_____/_____

What is the probable period of disablement **:** _____

Declaration

I/We declare that I/We have not withheld any material information and that all statements made on this form are true to the best of my/our knowledge and belief. I/we understand that the claim may be refused if the information is untrue, inaccurate or concealed.

Signature of authorized signatory

Date :

Company seal :

Documents to be submitted (as relevant to the specific claim) along with claim form:_

- FIR
- Medical certificate/treatment documents
- Fitness Certificate
- Death certificate
- Post Mortem Certificate
- Age proof
- Statement of witness
- Summons from WC Commissioner
- Report to Inspector of Labour
- Petition

STATEMENT OF WAGES

The purpose of this statement is to ascertain the injured person's average monthly earnings, hence provide the details carefully and accurately.

Please provide details of injured person's wages for the last 12 months immediately preceding the accident or for shorter period in case employed for less than 12 months. In case he has been employed for less than 1 month, then enter the wages paid to another workman employed for similar work during last 12 months. In case there is no workman engaged in similar work, enter the wages paid to injured workmen himself during whatever period he has been in your employment. If injured person is a daily wager, give the daily rate of wages and average number of days the injured person would have worked in a month.

Month and year (Fill in specific dates for each month)	Wages	Overtime Allowance	Bonus	Value of food subsidy, free quarters,	Period of absence

				any other allowance	
__/__/___ to ___/___/___					__/__/___ to ___/___/___

The above statement of wages is accurate to the best of my/our knowledge and belief.

Signature of employer/authorized signatory :

Date :

Company Seal :

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