EMPLOYER'S LIABILITY - CLAIM FORM

- Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.
- Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.
- Please return this form, duly filled & signed, within 3 days, from the date of receipt of this claim form.

Policy Number:	**Claim No:**
Period of Insurance: From	**To**

1.	Name of the Employer / Insured	
2.	Address for communication P.B.No. P.C.No. Location	
	Tel. No GSM NO. Fax No. Email Id	
3.	Business / Location	
4.	Name & address of the injured person	
5.	Date of birth/age of the injured person	
6.	State occupation in which the injured person is employed.	
7.	State fully the nature of work the injured person was doing at the time of accident.	
8.	Is the injured person in your direct employment? If yes, when did the injured person enter your service. If not, for whom and in what capacity he was working at the time of accident.	Yes / No
9.	Name & address of the hospital taken to	
10.	Was he/she treated as In or Out patient	Yes / No

11.	State whether still in hospital or when discharged.	
12.	Has the injured person medically examined? If yes, please send report. If not, was free medical treatment offered?	Yes / No
13.	State whether returned to work and if so, when?	
14.	Are you satisfied that the injured person has met with a bonafide accident of employment?	Yes / No
15.	Is the injured person able to do partial work?	Yes / No
16.	What is the probable period of the disablement (approximate)?	
ACCIDENT DETAILS		
1.	Date/ Time/ 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 cease work?	
4.	State how this accident occurred? If from Machinery Whether it was fenced or guarded? Was it being cleaned whilst in motion?	 Yes / No Yes / No Yes / No
6.	What was the general nature of the contract or work going on?	
7.	State nature of injury	
8.	State regions injured	
9.	State right or left side	
10.	Was the injured person under the influence of alcohol or drugs at the time of accident?	Yes / No.
11.	Was he guilty of any misconduct or Disobedience to orders or rules? If so, please give full particulars	Yes / No
12.	State through whose negligence, it occurred, If any.	
13.	State the names of persons who witnessed the accident.	

14.	Have the police and Labor Department been duly informed within 24 hours after receiving notice of the injury?	

I/We hereby confirm that the responses and information provided in this form are true and correct. I/We also confirm having noted that any false disclosure of information OR failure to provide adequate disclosure of information shall render this claim invalid.

Place:
Date: **Signature of the Employer**