

# Householder's Package Policy (Retail)

## Employee's Compensation Insurance

### Claim Form



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### 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 MHDI.*

#### 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, any other allowance	Period of absence
__/__/__ 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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