Shopkeeper's Package Policy (Retail)

Workmen Compensation 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

Documents to be submitted (as relevant to the specific claim) alongwith 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