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WORKMEN'S COMPENSATION INSURANCE NOTICE ACCIDENT

N.B.

1. Full particulars of the accident are to be furnished by the Employer.
2. Giving the under mentioned information does not imply that the injured person is making, or will make, claim.
3. This form is sent without prejudice to the terms of the Policy.
4. If any details or information are not readily available, please forward this form without delay not later than 3 months from the date of the accident and supply the missing details as soon as possible.
5. All written communications received by the Employer concerning the accident to the employee should be forwarded at once to the Company.

The Employer

Name of Policy – holder _____

Business _____ No of Policy _____

Address _____ Claim No _____

_____ Phone No _____

The Injured Person

Name _____ Occupations _____

Address _____

_____ Date of birth _____

I.D Card No _____

State occupation in which the injured person is employed _____

On what exact work was he/she engaged at the time of accident _____

Is the injured person in your direct employ? Yes No

Is the injured person under contract? Yes No

If Yes, give name and address of contractor _____

And nature of contract _____

Was the injured person taken to hospital? Yes No

If yes, kindly submit / indicate _____

1. Diagnosis card, checkicket, medical certificate _____

2. Name of hospital _____

3. Date of admission _____ Discharge _____

What is the approximate period of incapacity? _____

Was the injured workman subject to any physical

Infirmity or deformity at the time of accident Yes No

If yes, dive details _____

When did the injured person enter your service? _____

Are you satisfied that the injured person has met with a Bona fide accident arising from his employment? Yes No

Is the injured person able to do partial work? Yes No

Have you made any other claim in respect of this workman under the present policy or any other policy? Yes No
If yes, give policy/claim No _____

Has the injured person returned to work? Yes No

If yes, when? _____

The Accident

Date _____ Time _____

Place _____

On what date did you receive notice of accident _____

And from whom? _____

State through whose neglect if any, the accident _____

Occurred _____

State full details of accident _____

Was the accident due to machinery or gearing? Yes No

If yes, whether it was fenced or guarded? Yes No

Being cleaned whilst in motion? Yes No

Was he guilty of misconduct or disobedience to _____

Orders or rules? Yes No

If yes, give details _____

Did the injured workman actually cease work after the accident and on what date did the worker cease work? _____

Did the accident occur outside your work premises? Yes No

If yes, give details _____

State nature of injured regions right or left side

Was worker under influence of drugs / drinks at the time of accident? Yes No

State names of persons who witnessed accident _____

SAFETY FIRST : What precautions have you taken to prevent a repetition of this or similar accidents in future? _____

To whom was the accident reported _____

Additional Particulars For Fatal Cases Only

Has the deceased any dependants? Yes No

If yes, state names, address, sex relationship, ages, and occupations _____

In connection with FATAL cases please forward a copy of Police report and death certificate

Statement of insured Workman's Earnings

The object of this part of the Form is to ascertain the exact average monthly earnings of the injured person and therefore if is very important that the under mentioned particulars are accurately completed.

1
Month & Year

2
Basic Salary

Please indicate the specific dates, the workman was absent from work.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 11. _____
- 12. _____

Total earnings in the period
From To Total including allowances Rs.....
Monthly average wages Rs

- NOTES: 1. Please submit in column (2) above total monthly earnings of the worker for 12 months prior to date of accident for example, if date of accident was 02.09.1990 the earnings that should be submitted are from 03.09.1989 to 02.09.1990
2. If the worker's period of service was less than one month, please give the average monthly wages of a workman employed on the same work or if there was no workman so employed of a workman employed on similar work in the same locality Rs _____
3. The cost of medical certificate issued by a Government institution will be reimbursed subject to a maximum of Rs 20/- on production of the receipt.
4. Remarks: _____

The replies given are correct to the best of my/our knowledge or behalf

Signature _____

Date _____

Designation _____