Workmen's Compensation Insurance
Notice of Accident

Orient Insurance Ltd (PB 4720)
Head Office 133, New Bullers Road,
Colombo 04,
Sri Lanka
Tel (+94 11) 203 0300

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 a claim.
3. His 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 the Policy Holder ----------

Business ---------- No. of Policy ----------

Address---------- Phone No ----------

The injured Person

Name---------- Date of birth ----------

Address ----------

---------- I.D. card No. ----------

State occupation in which the injured person is employed---------- Sex ----------

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

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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 ----------

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

Was the injured person taken to hospital ☐ Yes ☐ No
If yes, kindly submit/indicate

1. Diagnosis card, BHT, 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.

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 / Cliam No----------
Has the injured person returned to work ?
If yes, when ?----------

If yes give details ----------

The Accident

Date ---------- Time----------
Place----------
On what date did you receive notice of accident
And from whom ?----------
State through whose negligence if any, the accident
Occurred----------

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?
If yes, give details. ----------

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 of rules ? ☐ Yes ☐ No

If yes,give details----------

State nature of injured regions right left side ----------

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

State names of persons who witnessed accident----------

SAFTY FIRST : What precautions have you taken to prevent a repetition of this similar accidents in future ? ----------
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To whom was the accident reported----------

Additional Particulars for Fatal cases Only

Has the deceased any dependants ? ☐ Yes ☐ No

If Yes, state names, addresses, sex, relationship, ages, and occupations ----------

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

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Statements 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 it is very important that the under-mentioned particulars are accurately completed

1	2 TOTAL EARNINGS				
Month & Year	Wages Salaries Commissions, Bonuses And Overtime		Value o Board and/or Lodging and/or other considerations		Please indicate the specific dates, the workman was absent from work.
	Rs.	Cts.	Rs.	Cts.	
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 wage Rs.....

Notes :

1. Please submit in column (2) above total monthly earnings of the worker for q12 month's prior to date accident for example , if date accident was 02.09.1999 the earnings that should be submitted are from 03.09.1998 to 02.09.1999.
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 workmen so employed of a workman employed on similar work in the same locality Rs. ----------
3. The cost of medical certificates issued by Government institution will be reimbursed subject to a maximum of Rs. 25/= on production of the receipt.
4. Remarks :----------

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

Name & Designation:----------
Signature ---------- Date----------
Company Rubber stamp----------