TATA-AIG GENERAL INSURANCE COMPANY LIMITED
Ahura Center,4th Floor , Mahakali Caves Road, Andheri(E), Mumbai-400093

CLAIM FORM – WORKMEN COMPENSATION INSURANCE

IMPORTANT :Issuance of this form is not to be taken as an admission of liability nor answering these questions implies that the injured person is making, or will make a claim. **If any detail of information is not readily available please do not delay despatch of this report. Such particulars may be sent later.** ***All written communications should be forwarded to the Company at the address below.***

POLICY NUMBER: **CLAIM NO.:**

THE EMPLOYER/INSURED		
1.	Name of Policyholder	
2.	Business	
3.	Address Phone Number:	
THE INJURED PERSON		
1.	Name	Age Sex
2.	Local/Permanent Address	
3.	State occupation/nature of work of the injured person	
4.	Was the injured person engaged in this occupation when the accident occurred? If not, state exactly the nature of the work he was doing at the time of accident.	
5.	Is the injured person in your direct employment? If not give name and address of Contractor, under whom employed and nature of work entrusted to contractor.	
6.	When did the injured person enter your service?	
7.	Has the injured person been medically examined or hospitalised? If so, please send copy of Medical report.	Medical Report Enclosed **Yes** ☐ **No** ☐
THE ACCIDENT		
1.	Date Time	Place
2.	State how this accident occurred	
3.	Date of notice of accident and by whom? If in writing please attach it to this form.	
4.	Time and date when the injured person actually ceased work.	
5.	How long is the disablement expected to last? (Copy of Fitness certificate of attendant doctor to be obtained after returning to work.)	
6.	Was the accident reported to Police or Inspector of Labour (A copy of report to be attached)	
7.	State nature of injury & part of body affected	
8.	Was the injured person under the influence of alcohol or drugs at the time of accident? If yes, give details.	

I declare that to the best of my knowledge and belief these particulars are full and true. I agree to provide any further information that may be required.

Place:
Date: Signature of Policyholder

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STATEMENT OF WAGES

The object of this statement is to ascertain the injured person's average monthly earnings. Please therefore observe the following instructions very carefully. Failure to do so will entail unnecessary correspondence and cause undue delay in the settlement of the claim: -

1. If the injured person has been in the service during a continuos period (not broken by an absence of 14 or more consecutive days) of 12 months or more, then enter the wages paid to him in each month during 12 months immediately preceding the accident.
2. If he has been in the service during a continuous period of less than one month, then enter the wages paid to another workman employed on similar work during 12 months immediately preceding the accident .
3. In all other cases, the monthly wages shall be the average daily earnings (Amount of Wages/Actual number of days worked) multiplied by 30.

TABLE OF WAGES

Please fill in the table of wages below as applicable to 1,2 or 3 above.

Month and year	Basic pay and Dearness Allowance	Overtime Bonus	Concession in value of food-stuffs and others	All others

Total earnings in the period(specify dates)

Average monthly wages

Were the above stated wages paid, or fallen due for payment, to the injured person? **Yes** ☐ **No** ☐

(a) Was the injured person absent from work at any time, during the above stated period, for 14 or more consecutive days? …………………………………………………………………………………….
If so, give the following particulars: -
Absent for …………………………..days from ……………………………to…………………………….

The above statement of earnings is accurate to the best of our knowledge and belief.
Place:

Date: Signature of Employer

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MEDICAL REPORT
(To be filled up by attending doctor)

1. Name of injured person……………………………………………………………………………………….
2. Age……………………………………………3. Sex……………………………………………………….
4. Full description of the nature and extent of injuries…………………………………………………………
……
……
……
5. Is the disablement for work :-
** (A) Total or Partial ?………………………………………………………………………………………….
(B) Solely the result of the Accident? ……………………………………………………………………….
(C) Partly due to some previous Accident or illness? If so to what extent …………………………………
……
6. How long is the disablement likely to continue ? ……………………………………………………………….
7. If the disablement is permanent , please state what is the percentage of loss of earning capacity resulting therefrom (vide Schedule on the reverse)……………………………………………………………………….
……
8. Is any improvement possible ? If so , state what treatment you recommend and to what extent the disablement is likely to be reduced if it is carried out………………………………………………………………………
……
9. Present general condition of Health and injury/ies of the injured person
………..
10. Does the examination point to the injured Person being :-
(a) Addicted to Drink or Drugs ……………………………………………………………………………
(b) Disposed to Malinger……………………………………………………………………………..
11. Remarks………………………………………………………………………………………………
………..
……
…….

Signature ____________________________
Qualifications ____________________________
Address ____________________________
____

Date ___/___/_______

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