WORKERS COMPENSATION CLAIM FORM

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Agency .... Claim No. ....
Policy No. .... Due ....
Sum Insured .... Excess ....
Noted on proposal ....
Premium Paid .... Receipt No. ....

TO BE COMPLETED BY THE EMPLOYER - NOT BY THE INJURED WORKER

THE REPORT is to be completed as accurately as knowledge of the circumstances permits, and forwarded AS PROMPTLY AS POSSIBLE, to SUN INSURANCE COMPANY Limited together with any available medical evidence in support of incapacity of the worker. NO PAYMENTS FOR COMPENSATION OR OTHER EXPENSES ARE TO BE MADE UNTIL THE AUTHORITY OF THE COMPANY HAS BEEN OBTAINED.

EMPLOYER:

1. Name of Employer .... Business or Profession ....
2. Address .... Telephone No: ....

INJURED EMPLOYEE:

3. Name of Injured Person ....
4. Address .... Occupation ....
5. Industry in which employed .... How long in your employment? ....
   e.g., Farming, Coal Mining, Clothing Manufacturer, Road Construction, Flour Milling.
6. State the operation at which the Worker was engaged at the time of accident ....
7. (a) Was injury sustained in the course of the Worker's employment with you? ....
   (b) Did injury arise out of the Worker's employment with you ....
   (c) Was the Worker in the service of any other employer at the time? ....
8. Was the Worker injured while doing something which it was no part of his particular employment to do, or was he injured at a place or part of the works where he was not required to be by his particular employment? ....
9. SCHEDULE

Age.	Married or Single.	No. of children under school leaving age.	Number of days worked per week.	Total earnings in your employ for previous 12 months (or part thereof).	Average weekly earnings	Is board and lodging provided in addition to weekly wages?	Date and Time discontinued working	Number of hour worked per week	Length of time worked on day when injury occurred.
							Date: Time: am. pm.	Number Hours: am. pm.	

10. Is the injured person related to you? .... If so, what is the relationship and does he or she reside with you? ....
11. State clearly if injured person is casual, permanent, or working under contract ....

PARTICULARS OF ACCIDENT:

12. Day of week .... Date .... Time .... am. pm.
13. State exact place or locality where injury was sustained ....
14. Did the injured person give notice of injury? .... To whom was it given? ....

NOTE:-If the worker failed to give notice of the injury as soon as practicable after its happening, he is required to supply a written signed statement containing his explanation, and showing reasonable cause why notice of unjury was not so given.

   (a) when it was given .... am. pm. Date .... Verbally or in writing ....
   (b) Give the names of persons who were actual eye witnesses of the injury ....
15. State fully how injury was sustained ....
16. What is the nature of injury? ....
17. If the injury was cause by any person or persons not in your employ please advise full names and addresses of those concerned ....

It is necessary for THE RESPONSIBLE PERSON MAKING THIS REPORT to satisfy himself that the information given herein is in accordance with the facts. The injured worker's own statement regarding the injury is NOT acceptable without proper support.

COMPENSATION DETAILS:

18. (a) Has the injured person return to work? ....
   (b) If so, when? ....
19. Is compensation being claimed or received from any other source? ....

OFFICE USE ONLY
Amount p.w $ ....
From ....
To ....

20. Was the injured person free from physical infirmity at the time of the accident? ....

21. Are you aware whether the Worker has ever previously suffered from a similar injury? ....

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22. Was the part affected by this accident quite normal before the accident? If not give full particulars ....

23. Would such physical defect or infirmity have contributed towards this accident? ....

24. If the "Worker" has received any medical surgical, or hospital treatment please state under which Doctor or of which Hospital and forward medical certificate if available.

Name of Hospital ....

Whether in-patient or out-patient ....

Name and Address of Doctor ....

Supplementary remarks as to anything affecting the cause or probable consequences of the injury.
(If it is considered practicable to give an opinon, please state the approximate priod of incapacity which it is expected will result from the injury)

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(Please carefully read the notes below before signing)

Signature of Employer..

Date..

NOTE-1 The Company will require an explanatory report in the event of :-

(a) The injury being caused by any defect in works, ways, machinery, or plant.