Universal Sompo General Insurance Co. Ltd.

(A joint venture between Allahabad Bank, Sompo Japan Insurance Inc., Indian Overseas Bank, Karnataka Bank and Dabur Investments.)

Regd. Office: 201-208, Crystal Plaza, Opp. Infiniti Mall, Link Road, Andheri (West), Mumbai - 400 058.

WORKMEN COMPENSATION INSURANCE CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

If any detail or information is not readily available please do not delay dispatch of this form and such particulars may be sent later.

Policy No. ____________________ Claim No. ____________________

A. INSURED

Name ____________________

Address line 1 ____________________ City ____________________ Pin Code ____________________

Address line 2 ____________________ State ____________________

Phone No. ____________________ Mobile No. ____________________ Email ____________________

Business/Occupation ____________________ Period of Insurance From _ _/_ _/_ _ _ _ To _ _/_ _/_ _ _ _

Limits of Indemnity under the Policy ____________________

B. DETAILS OF LOSS

Date of Loss _ _/_ _/_ _ _ _ Time _ _:_ _ AM / PM

LOSS LOCATION

Address line 1 ____________________

Address line 2 ____________________

City ____________________ State ____________________ Pin Code ____________________

Phone No. ____________________ Mobile No. ____________________ Email ____________________

Describe cause of Loss/Damage ____________________

____

Estimated Loss (Rs.) ____________________

WITNESS DETAILS

Is any witness available for accident / loss? ☐ Yes ☐ No

If "Yes", specify

Name of the witness ____________________

Address line 1 ____________________

Address line 2 ____________________

City ____________________

State ____________________

Pin Code ____________________

Phone No. ____________________

Mobile No. ____________________

Email ____________________

INFORMATION TO AUTHORITY

Have any authority been informed about Accident / Loss? If "Yes", specify ☐ Yes ☐ No

Name of the Authority ____________________

Contact Person ____________________

Authority reference no. ____________________

Address line 1 ____________________

Address line 2 ____________________

City ____________________ State ____________________

Pin Code ____________________

Phone No. ____________________ Mobile No. ____________________

Email ____________________

C. DETAILS OF OTHER INSURANCE

Is the Loss/damage covered under any other Insurance? If "Yes", specify details and attach copy of policy ☐ Yes ☐ No

Name of the Insurer ____________________

Address line 1 ____________________

Address line 2 ____________________

City ____________________ State ____________________ Pin Code ____________________

Phone No. ____________________ Mobile No. ____________________

Policy No. ____________________ Email ____________________

Period of Insurance From _ _/_ _/_ _ _ _ To _ _/_ _/_ _ _ _ Amount of Insurance ____________________

D. THE INJURED PERSON

Name of the Injured Person ______________________________

Date of Birth __/__/____ Age ________

Gender ☐ Male ☐ Female

Address line 1 ______________________________

Address line 2 ______________________________

City ____________ Pin Code ____________

State ____________ Phone No. ____________ Mobile No. ____________

State occupation/nature of work of the injured person ____________

Was the injured person engaged in this occupation when the accident occurred? ____________

If "No", state exactly the nature of the work he/she was doing at the time of accident ____________

Is the injured person in your direct employment? ☐ Yes ☐ No

If "No", give details

Name of the Contractor ______________________________

Address line 1 ______________________________

Address line 2 ______________________________

City ____________ Pin Code ____________

State ____________ Phone No. ____________ Mobile No. ____________

Nature of work entrusted to contractor ____________

When did the injured person enter your service? __/__/________

Have the injured persons been taken to hospital or medically attended? If "Yes", specify ☐ Yes ☐ No

Name of hospital / physician ______________________________

Date of Admission __/__/________ Date of Discharge __/__/________

Address line 1 ____________ Address line 2 ____________

City ____________ State ____________ Pin Code ____________

Phone No. ____________ Mobile No. ____________ Email ____________

E. INJURY DETAILS

State nature of injury & part of body affected ____________

Is there disablement? ☐ Yes ☐ No

If "Yes", select ☐ Total ☐ Partial ☐ Permanent ☐ Temprorary

Is the Disability solely caused by this accident / Incident ☐ Yes ☐ No

If "No", give details ______________________________

How long is the disablement expected to last? ___ Days Upto __/__/________

Extent of disability ______%

Is any improvement possible from current disablement % ? ____________ ☐ Yes ☐ No

If "Yes", specify with % improvement and action required ____________

Time and date when the injured person actually ceased work. Date __/__/________ Time ____:__ ____ AM / PM

Was the injured person under the influence of alcohol or drugs at the time of accident? ☐ Yes ☐ No

Present health condition ____________

Death Examination point of ☐ Addiction to drugs / alcohol ☐ Disposed to Malinger

Any other Details ______________________________

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/we agree that if I/We have made, or in any further declaration, the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void, and all rights to recover thereunder in respect of past or future loss/accidents shall be forfeited.

Place: **Signature:**

Date: **Name of Insured:**

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

Was the injured person absent from work at any time, during the above stated period, for 14 or more consecutive days? ☐ Yes ☐ No

If "Yes", period of absence from _ _/_ _/_ _ _ _ _ _ _ _ to _ _/_ _/_ _ _ _ _ _ _ _

Reasons for absence ____

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

Place: **Signature:**

Date: **Name of Insured:**