



OCCIDENTAL INSURANCE COMPANY LIMITED

Crescent Business Centre, 7th Floor, Parklands Road, Parklands,

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CERTIFICATE to be completed and signed by an eye witness and if possible by the person under whose direction the Workman was at the time of the Accident

I hereby certify that I was present when the Accident occurred to _____

_____ on the _____ day of _____

in manner above stated - that it was caused by _____

_____ which was * / was not * his wilful act and

that he was* / was not * under the influence of drugs or alcohol at the time.

Signed : Name _____
Address _____
Occupation _____

* strike out which is not applicable.

WORKMEN'S COMPENSATION INSURANCE CLAIM FORM

IMPORTANT NOTICE

1. No liability under the policy is admitted by issue to this form.
2. Do not answer any third party communications about this Accident, but send them to us for action.
3. All Questions on this form must be answered.
4. Notwithstanding this form, you are required to comply with all the provisions of the Workmen's Compensation Act (Cap.236) relating to the procedure of reporting accidents, etc.

Section 'A' Employer

Name _____ Policy No: _____

Address _____

Period covering accident: From: _____ To: _____

Business or occupation _____

Telephone: _____

Section 'B' Injured workman

1. Name and address : Mr/ Mrs / Miss _____

2. a. Usual Occupation _____

b. Age _____ Sex _____

c. Married or Single _____

d. Identity Card Number _____ Attach Copy.

3. Was he / she in your direct employ or in that of a sub-contractor?

4. If in your employ, how long has he been so employed? _____

5. Give details of total earnings declared for insurance _____

6. Give details of total monthly earnings at the of the accident.

Wages - _____ Shs _____ per month

Rations - _____ Shs _____ per month

Housing- _____ Shs _____ per month

other earnings/
allowance Shs. _____ Shs. _____ per month

TOTAL _____ Shs _____ per month

7. State precisely the nature of the work he / she was doing at the time of the accident _____

8. How did the accident occur? _____

9.a. When did the accident occur? State time, date and place

_____ am / pm on _____ at (place) _____

b. When did the injured employee cease work on account of accident?

State date:- _____

10.a. Was he performing a duty for which he was employed?

b. Was he obeying any rule or order? _____

c. Was the accident due to another person's negligence? _____

If so, give particulars _____

d. Was the accident due to any defect of machinery or plant?

e. Had such defect been brought to your notice? _____

11. Did you take all reasonable precautions to prevent accidents of the nature occurring? If so, state fully the nature of the precautions taken. _____

12. Was the injured person under the influence of drugs or alcohol at the time of the accident?

13.a. Under whose direction and control was the injured workman working at the time of the accident?

b. Did the accident occur whilst he was under such direction and control? _____

14.a. Was the injured person suffering from any ill-health or bodily defect at the time of the accident

b. Were you aware of such ill-health or defect? _____

15. State fully the nature of the injuries received _____

16.a. Name and address of injured Workman's Medical Attendant

b. If in hospital or nursing home, give name and address

17. State how long was the injured workman off duty as a result of the accident? _____

18. Does the workman still suffer any disability? If yes, state the nature of the disablement

19. State whether the injured workman is still in your employment _____

I hereby certify that the above statement is full and true account to the best of my knowledge and belief .

DATE THIS _____ DAY OF _____ 20 _____

EMPLOYER'S SIGNATURE
& CO. RUBBER STAMP
