DONEWELL INSURANCE COMPANY LIMITED

WORKMEN'S COMPENSATION CLAIM FORM

(The company does not admit liability by the issue of this form)

DATE FORM WAS COLLECTED ..... *DATE FORM WAS RETURNED* .....

I/We give you hereunder particulars of an accident to one of our workmen and shall be glad to furnish any further information you may require.

Policy No.....Trade or Business.....

Date .....Address .....

Employer's Signature .....

DETAILS OF INJURED WORKMAN	
1. (a) Full Name	(a)
(b) Address	(b)
(c) Occupation.....Age	
(d) State if married and number of Children	(d)
(e) Amount of weekly earnings	(e)
(f) He is in direct employ of	(f)
(g) How long has he worked for you?	(g)

2. The accident happened at.....a.m./p.m. on the.....day of..... 20... at.....

3. The injured workman ceased work on the.....day of..... 20.....

4. The accident happened thus: - [N.B. Please give fullest possible description, stating particularly if caused by machinery, or by the fault of any person. In the latter case give name of person, and state by whom employed. (Attach extra sheet if necessary)

5. The workman sustained the following injury or has contracted the following disease:

6. The workman and address of witnesses are:-	[1] ..... [2] .....

IMPORTANT.

IN THE EVENT OF THE ACCIDENT RESULTING IN DEATH, IMMEDIATE NOTICE MUST BE GIVEN TO THE COMPANY BY FAX, LETTER OR TELEPHONE.