HDFC General Insurance Limited
(Formerly L&T General Insurance Company Limited)
An HDFC ERGO Company

Workmen's Compensation Insurance - Claim Form

GUIDELINES TO FILL THE FORM

1. Please fill the form in BLOCK LETTERS. Please answer all questions fully and correctly.
2. Please leave one box blank between two words while writing the ADDRESS.
3. Kindly leave the Company's Office or Intermediary for any doubts or clarifications on the claim form.

PLEASE USE ONLY ORIGINAL CLAIM FORM. PHOTO COPIES WILL NOT BE ACCEPTED BY THE COMPANY.

FOR OFFICE USE ONLY
Intermediary Name:
Intermediary Code:

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

As soon as Loss or Damage has become known, the Company must be notified without delay. If any detail or information is not readily available, please do not delay dispatch of this form and such particulars may be sent later.

Claim No: Policy No/Cover Note No:

Period of Insurance: D D M M Y Y Y Y To D D M M Y Y Y Y

Certificate No:

Customer ID:

POLICY HOLDER INFORMATION (Please enter details of the Insured)

Title* (Pls. Tick): Ms. Mrs. Mr.

Name*: F I R S T M I D D L E L A S T

Correspondence Address:

Block/Flat No.*: Floor No.: Building Name*:

Street Name*: Locality:

Landmark*:

City/Village*: Pincode*:

Post Office:

Mobile No.*: Landline*: S T D

Fax No.:

Email ID 1:

Email ID 2:

BANK DETAILS (Required for Electronic Fund Transfer)

Name of the Account Holder:

(as appearing in the Bank Account)

Bank Name:

Branch:

Location:

Account No:

Account Type:

MICR Code:

IFSC Code:

INJURED PERSON DETAILS

- Name, Address and Contact details of injured person: .....

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- Name, Address and Contact details of dependents of injured person: .....

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- State fully the nature of work the injured person was doing at the time of the accident: .....

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

  If yes, when did the injured person enter your service? .....

  If not, provide name and address of contractor and nature of contract: .....

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- Name and address of the hospital taken to: .....
- Was he treated as In or Out-Patient? ☐ In-Patient ☐ Out-Patient
- State whether still in Hospital or when discharged: .....
- Has the injured person been medically examined? ☐ Yes ☐ No

  If yes, please send report .....

  If not, why was no medical examination offered? .....
- State whether returned to work ☐ Yes ☐ No
- If so, when? D D M M Y Y Y Y
- Are you satisfied that the injured person has met with a bona-fide accident of employment? ☐ Yes ☐ No
- Is the injured person able to do partial work? ☐ Yes ☐ No
- What is the probable period of disablement (approximate)? .....

ACCIDENT DETAILS

Date: D D M M Y Y Y Y Time: H H : M M Place: .....

- When did you receive notice of accident and from whom? (If in writing, please attach it to this form) .....

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- How did the accident take place? .....

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- Location of accident: .....

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- On what date did the injured person actually cease work? D D M M Y Y Y Y
- State how this accident occurred: .....

  .....

- If from machinery:

  a) Whether it was fenced or guarded? ☐ Yes ☐ No

  b) Was it being cleaned whilst in motion? ☐ Yes ☐ No

- What was the general nature of the contract or work going on? .....
- State nature of injury: .....
- State regions injured: .....
- State whether right or left side: .....
- Was the injured person under the influence of alcohol or drugs at the time of the accident? ☐ Yes ☐ No
- Was he guilty of any misconduct or disobedience to orders or rules? ☐ Yes ☐ No

  If so, please give full particulars: .....
- State through whose neglect it occurred, if any: .....
- State the names of persons who witnessed the accident: .....

DECLARATION

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 make in any further declaration, the Company may require in respect of the said accident, any false or fraudulent statement, or any suppression or concealment or any material information, my/our claim shall be absolutely forfeited, and the policy shall be null and void, and all rights to recover there under in respect of past or future loss/accident shall be forfeited.

I/We authorize HDFC General Insurance Limited to share my/our contact information like name, company name, address, phone number and e-mail id etc. relating to me/us, with their affiliate/group companies and also for communicating any promotional marketing offers and other transactional/features/products/ services of HDFC General Insurance Limited and its affiliate group companies via ☐ SMS ☐ Telephone

Place: .....

Date: .....

Signature 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.

- If the injured person has been in the service during a continuous period (not broken by an absence of 14 or more consecutive days) of 12 months or more, then enter the wages, etc; paid to him in each month during 12 months immediately preceding the accident.
- If he has been in the service during a continuous period of not less than 12 months but more than a month, then enter the wages, etc; paid to him in each month during such period immediately preceding the month.
- If he has been in the service during a continuous period of less than 1 month, then enter the wages paid to another workman employed on similar work during 12 months immediately preceding the accident i.e. accident to the workman in respect of whom the claim is being submitted.
- If you have no workman employed on similar work, then enter the wages, etc; paid to the injured workman himself during whatever period of service he has put in immediately preceding the accident.
- Please specify the period for which wages have been entered in this Statement by mentioning the date of the beginning of the period and the end of the period, which should be the date prior to the accident.
- Please do not mention merely the rate of wages. Give full details as above.

Month Wages Bonus, Value of Free quarters,

₹ |_|_|_|_|_|_| Np. ₹ |_|_|_|_|_|_| Np. Any other allowances

Total |_|_|_|_|_|_|

Total including all allowances

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

If No, state to whom: .....

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, give the following particulars:

Absent for ..... days from ..... to .....

Absent for ..... days from ..... to .....

Absent for ..... days from ..... to .....

Absent for ..... days from ..... to .....

Date: .....

Place: .....

Signature of Employer