

The Oriental Insurance Company Limited Head Office, A-25/27, Asaf Ali Road, New Delhi-110 002

Issuing Office

EMPLOYERS LIABILITY CLAIM FORM

PARTICULARS OF ACIDENT TO BE FURNISHED BY THE EMPLOYER

These questions are to be answered whether or not a claim from the injured person has been made or is anticipated.

The Insurer does not admit liability by the issue of this form

NB- If any details of information are not readily available PLEASE DO NOT DELAY DESPATCH of this form but send supplementary advices later.

PART-I : THE EMPLOYER						
 Name of Policy holder Business 	5. Policy No					
3. Address (and nearest railway station)4. District						
PART-II: THE INJURED PERSON						
 Name Religion or caste Local Address Mofusil address Occupation in which injured person is employed Was the injured person actually Working when the accident occurred? Is the Injured person in your direct employ ?(if not, give name and address of contractor and nature of contract) Name of the Hospital taken to State whether still in hospital or when discharged. State whether still in hospital or when discharged State nature of injury, regions injured and whether left or right. 	8. Age9. Sex					
20. Did injured person actually cease work, and if so, on what date?21. Has injured person resumed duty since and if so, on what date?22. What is the probable period of disablement (approximate)?23. Was the injured person free from						
physical infirmity at the time of the accident? If not, give particulars.						

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PART - III					
24. Date of Accident 25. Did the accident occur actually within your work premises? If not, where did it occur? 26. On what date did you receive notice of accident and from whom? If in writing please attach to this form 27. Are you satisfied injured person met with a bonafide accident of employment? 28. How exactly did the accident occur? 29. If accident due to machinery, state- a) whether it was fenced or guarded b) was it being cleaned whilst in motion 30. Was injured person under the influence of drink or drugs at the time of the accident? 31. Was he guilty of any misconduct or disobedience to order or rules? I so, please give full particulars. 32. State through whose neglect if any, it occurred	TimePlace				
32. State through whose neglect if any, it occurred33. State the names of any two persons who					
33. State the names of any two persons who witnessed the accident.34. Give name of over looker or person in superintendence.					

The above replies are accurate to the best of my knowledge and belief:

Date	Signature of Employer

STATEMENT OF INJURED PERSON'S EARNINGS

State	ment of wages which have fallen of						
	e date of his accident or wages	annad during	auch sho	rtar paried as	10	r 12 months period	
	oyor's service.	earned during	such shor	iter period as	s ne may	nave been in the	
perso servi conti	The object of this part of the for on. It is essential that it should be ce for less than twelve months hi nuously for more than 14 days (we cident, then the period of service s	e carefully and s date of entry ithin 12 months	correctly into services) between	filled in, if the ce is essentia the date of h	e injured l. So als is entry i	person has been in o if he was absent nto service and that	
Date	on which the injured person first e on which the injured person20				absence	of more that 14	
	Months and Year	Wages earned (Including overtime)		Value of bonus* food subsidy. If any free quarters and any other allowance etc.		Absences**	
1		Rs.	P.	Rs.	P.		
2		113.	1.	1131			
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
Total earnings in the period from							
		MON	THLY A	VERAGE WA	GES	RS	
SPECIAL NOTICES If the worker's period of service was less than one month, give the Average Monthly wages a Workman employed on similar work. Please state the exact nature of the allowance and or bonus In column "absences" please give date of going on leave or beginning of the period of absence and also date of subsequent resumption of work.							
The a	above statement of earnings, etc., is	s to the best of n	ny knowle	dge and belief	, accurate	2.	
Date	Signature of Employer (Add below any additional information available regarding the accident						
	(Au	a octow any auc	meronar illi	ominicion avai		nature of Employer	