REGD. OFFICE:
BHARTI AXA GENERAL INSURANCE COMPANY LIMITED,
RMZ Infinity, B - Tower, 2nd Floor, No. 3, Old Madras Road,
Bangalore - 560016. Tel: 080-40260100.
Toll-Free Helpline: 1800-103-2292
E-mail: claims@bharti-axagi.co.in
SMS <CLAIM> to 5667700
Website: www.bharti-axagi.co.in

bharti AXA general insurance

WORKMEN'S COMPENSATION/EMPLOYERS LIABILITY CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSIBILITY OF LIABILITY. LWC

Please fill this form in **Block Letters** and **Tick the Boxes** ☑ where appropriate and do not leave any column unanswered. If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

Policy Number: |_|_|_|_|_|_|_|_|_|_|

Claim Number: |_|_|_|_|_|_|_|_|_|_|

Period of Insurance: |D|D|M|M|Y|Y|Y|Y| to |D|D|M|M|Y|Y|Y|Y|

A. DETAILS OF INSURED

Name: _____

Address: _____

_____ Pin code: |_|_|_|_|_|_|_|_|

Telephone No.: _____

E-mail Address: _____

If Insured is not the sole owner, for the nature of his / their interest in the property and the details of other Interests, please respond to B below.

B. DETAILS OF PRINCIPAL / SUBCONTRACTORS

Name: _____

Address: _____

_____ Pin code: |_|_|_|_|_|_|_|_|

Telephone No.: _____

E-mail Address: _____

C. DETAILS OF INJURED/DECEASED PERSON

Name: _____

Father's/Husband's Name: _____

Age/Date of Birth: _____ Sex: ☐ Male ☐ Female

Local Address _____

_____ Pin code: |_|_|_|_|_|_|_|_|

Native Address _____

_____ Pin code: |_|_|_|_|_|_|_|_|

Occupation in which Injured/deceased person was employed: _____

_____

On what work was the Injured/deceased person engaged at the time of accident: _____

_____

Was the injured/deceased person actually working at the time of accident: _____

_____

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

If No, give name and address of contractor and nature of contract: _____

_____

_____

Who noticed the loss and when: _____

_____

Please attach a statement of the person

Circumstances leading to loss and cause: _____

Please attach separate sheet, if necessary

Give the employment record of the person.

Date of joining: D D M M Y Y Y Y

Continuous employment? If not, give details of break: _____

D. PLEASE FURNISH THE INJURED/DECEASED PERSONS EARNING DETAILS AS PER ANNEXURE 'A'

_____

_____

E. THE ACCIDENT

Date and Time of Accident: D D M M Y Y Y Y _____ (Hrs.)

The exact location of the Accident: _____

If the employee was under influence of intoxication at the time of accident: _____

_____

If the accident resulted in injury or it was fatal _____

If the employee was taken to hospital ☐ Yes ☐ No

If Yes, please submit the following

a) Treatment details/disablement certificate in case of injury/deceasement

_____

_____

b) Post-mortem report in case of death

_____

_____

If the incident was reported to Police ☐ Yes ☐ No

If Yes, please submit police report

If No, submit reasons for not doing so _____

_____

Was the employee guilty of any misconduct or disobedience to orders or rules _____

_____

Names of the witnesses if any _____

_____

I/We hereby declare that the above questions have been conscientiously and faithfully answered and would be liable for the correctness and completeness of the statement. I/We shall provide any additional information, if needed.
I/We also understand that issue of this form is not to be taken as an admissibility of liability.

Date: _____

_____
Signature of Employer

Place: _____

_____
Name and Designation

bharti AXA general insurance

ANNEXURE 'A'

Forming Part of Claim Number: |_|_|_|_|_|_|_|_|_|_|

WORKMEN'S COMPENSATION/EMPLOYERS LIABILITY CLAIM FORM

STATEMENT OF INJURED/DECEASED PERSON'S EARNING

Statement of wages fallen due to payment to _____ in the employment of _____ _____ for 12 months prior to the date of his accident or wages earned during such shorter period as he may have been in the employer service.

Note: The object of this part of form is to ascertain the extra average monthly earning of the injured person. It is essential that it should carefully and correctly filled in, if the injured person has been in service less than twelve months his dated of entry into service is essential so also if he was absent continuously for more than 14 days (within 12 months) between the date of his entry of resumption of duty

Date on which the injured person first entered service _____

Date on which the injured person resumed duty after a continuous absence of more than 14 days. _____

_____

Month and year	Wages earned (Including overtime)	Value of bonus, food subsidy, if any free quarter and any other allowance etc.	Absences
	Rs.	Rs.	
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
Total earning in the period			

Total including all allowance Rs. _____

SPECIAL NOTICE

If the workers period of service was less than one month give the) Rs.
average monthly wages a workman employed on similar work
*Please state the exact nature of the allowance and or bonus.
* In column absences give date of going on leave or beginning of the period of absence and also date of subsequent resumption of work

The above statement of earning etc. is to the best of my knowledge and belief accurate.

Date: _____

_____
Signature of Employer

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