

# WORKMEN'S COMPENSATION/EMPLOYER'S LIABILITY CLAIM FORM



Adamjee Insurance Co. Ltd.

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## PARTICULARS OF ACCIDENT(S) TO BE FURNISHED BY THE EMPLOYER

The questions are to be answered whether or not claim from the injured person has been made or is anticipated. The insurer does not admit liability by the issue of this form.

N.B. If any detail or information not readily available PLEASE DO NOT DELAY DESPATCH of this form but send supplementary advice later.

Claim No. \_\_\_\_\_

### PART I - THE EMPLOYER

1. Name of Policy holder	
2. Business	
3. Address	
4. District	5. Policy No. _____

### PART II - THE INJURED PERSON(S)

6. Name	
7. Religion or Caste	8. Age _____ 9. Sex _____
10. Local Address	
11. Mufussil Address	
12. Occupation in which injured person is employed	
13. On what exact work was injured person engaged at time of accident?	
14. Was injured person acutely working when accident occurred?	
15. (a) is injured person in your direct employment (b) if not give name and address of Contractor and nature of contract.	
16. Name of Hospital taken to.	17. in of out patient _____
18. State whether still in Hospital or when discharged	
19. State nature of injury, regions injured and whether left or right.	
20. Did injured person actually cease work after accident 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 injured person free from physical infirmity as item of accident? If not give particulars	

### PART III - THE ACCIDENT

24. Date of accident:	Time _____ Place _____
24. Did accident occur actually within your works premises? If not where did it occur?	
26. (a) On what date did injured person report accident? (b) To whom was report made	
27. Are you satisfied that injured person met with a bonafide accident of employment?	
28. How exactly did the accident occur? (Give full details )	
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 alcohol or drugs at item of accident?	
31. Was injured person guilty of any misconduct of disobedience to orders or rules? If so, please give full particulars	
32. State through whose neglect, if any, it occurred.	
33. State names of any two person who witnessed the accident.	
34. Give name of overlooker or person in superintendence.	

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

Date \_\_\_\_\_ 20

Signature & Stamp of Employer

(Please use reverse of form for any further information or attach a separate report)

## STATEMENT OF INJURED PERSON EARNINGS

Details of wages which have fallen due for payment to \_\_\_\_\_  
 \_\_\_\_\_ in the employment of \_\_\_\_\_  
 \_\_\_\_\_ for 12 months prior to the date of the accident, wages  
 earned during such shorter period as the injured person may have been in the Employer's service.

**NOTE:-** The object of the form is to ascertain the exact average monthly earnings of the injured person. It is essential that it should be carefully and correctly filled in. If the injured person has been absent from work at any time during the above period of employment, state the period and the cause.

MONTH AND YEAR	Wages earned (including overtime, bonus and all cash payments)		*Value of free quarters and any other allowance		ABSENCE
	Rs.	Ps.	Rs.	Ps.	
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
Total earnings in the period from to _____ TOTAL Rs.					

**Total Including all Allowance Rs.**

**Average Monthly Wages Rs.**

### SPECIAL NOTES

If the worker's period of service was less than one month give the average monthly wages of a workman employed on similar work.

Rs. \_\_\_\_\_

If worker was a daily paid employee, give (a) daily rate of wages, (b) number of days on an average that he/she would work in a month

(a) \_\_\_\_\_

(b) \_\_\_\_\_

\*State the exact nature of allowance \_\_\_\_\_ Are Free Quarters provided? \_\_\_\_\_

\*\* In column \*Absence\* give worker's date of going on leave or beginning of period of absence and also date of subsequent resumption of work.

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

\_\_\_\_\_  
**Signature of Employer**

(Add below any additional information available regarding the accident)

\_\_\_\_\_  
**Signature of Employer**

Date \_\_\_\_\_ 20