

**ANNEXURE VI****CLAIM FORM****EMPLOYEES' COMPENSATION POLICY**

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 any delay. If any detail or information is not available, please do not delay the dispatch of this form. Such particulars can be sent later. In any case, duly completed form together with relevant attachments and vouchers must be sent within fourteen days of the loss.

a) Name of the Insured / Employer

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b) Customer ID

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c) Address of the Insured

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Pin Code \_\_\_\_\_

d) Phone No.

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e) Contact Person

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f) E-mail Id: \_\_\_\_\_

**Claim Form – Employees' Compensation**

**Liberty General Insurance Limited**, Unit 1501 & 1502, 15th Floor, Tower 2, One International Center, Senapati Bapat Marg, Prabhadevi, Mumbai - 400013.

Phone: +91 22 6700 1313 Fax: +91 22 6700 1606, Email: [care@libertyinsurance.in](mailto:care@libertyinsurance.in)

Call Toll Free No : 1800 266 5844 ,website: [www.libertyinsurance.in](http://www.libertyinsurance.in)

IRDA of India registration number: 150 |CIN: U66000MH2010PLC209656

UIN No: IRDAN150P0032V01201213

g) Policy No.

h) Business / Occupation

\_\_\_\_\_

i) Details of injured person:

- Name \_\_\_\_\_
- Local/Permanent Address \_\_\_\_\_
- Age/Sex \_\_\_\_\_
- State nature of work for which the injured person was employed. \_\_\_\_\_
- Was the injured person engaged in the occupation when the accident occurred? If not, state exactly nature of work done at that time. \_\_\_\_\_  
\_\_\_\_\_
- Is the injured person in your direct employment? If so, state the date of appointment. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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j) Details of accident

- Premises / Exact location at which accident occurred.  
\_\_\_\_\_
- Time and date of occurrence of accident \_\_\_\_\_
- Date and Time when reported and to whom \_\_\_\_\_
- Time and date when the injured person actually ceased work. \_\_\_\_\_
- Describe how the accident occurred. \_\_\_\_\_  
\_\_\_\_\_
- Type of injury and part of body affected \_\_\_\_\_
- Hospital or doctor that is treating the injured \_\_\_\_\_

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- Date first sought medical treatment\_\_\_\_\_
- Are you satisfied that the accident occurred in the course of and arising out of employment? \_\_\_\_\_
- Was the injured person under the influence of alcohol or drugs at the time of accident? \_\_\_\_\_
- State whether the accident occurred as a result of negligence on the part of any employee. \_\_\_\_\_
- Has the accident been reported to police or inspector of labour? \_\_\_\_\_
- How long is the injured person expected to be in hospital? If discharged, date of discharge \_\_\_\_\_
- Even after release from hospital, does the person require further medication \_\_\_\_\_
- What is the medical opinion on the nature of injury / death / and extent of disablement?  
(A copy of the preliminary Medical Report to be attached)
- k) Have you got any other insurance covering the workman against EC, Personal Accident, E. S. I. Scheme? If so, give details\_\_\_\_\_
- l) Name of the witness and his statement  
\_\_\_\_\_  
\_\_\_\_\_
- m) Name of the witness and his statement
- n) Other work related injuries:
  - Has the employee previously suffered any similar injury / disease before?
  - Describe injury / disease and the parts of the body affected. Give approximate dates
  - What is the name of doctor, medical practice or hospital who treated him at that time?
  - Has he ever claimed for the injury / disease described?

- If yes, what is the approximate date of the claims? Who was the claim with? With whom was he working with at that time?

### 13. Journey injury

Complete only if the injury occurred away from the employer's premises or while he was on a journey to from work

- Mode of transport at the time of the accident
- Details of journey (to and from)
- What time did he leave?
- If he has deviated from his normal journey or if there was an interruption to the journey, please explain , why?
- Was the injury sustained outside the boundary of the land on which his work place / home is situated?

Declaration by Insured:

I/We hereby declare that the statements made by me / us in this claim form are true to the best of my / our knowledge and belief.

**Place:**

**Date:**

**Signature of employer**

[Add below any additional information available regarding the accident]