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

_____

b) Customer ID

_____

c) Address of the Insured

_____

_____

Pin Code_____

d) Phone No.

_____

e) Contact Person

_____

f) E-mail Id: _____

Liberty General Insurance Limited, 10th Floor, Tower A, Peninsula Business Park, Ganpatrao Kadam Marg, Lower Parel, Mumbai - 400 013
Phone: +91 22 6700 1313 Fax: +91 22 6700 1606, Email: care@libertyinsurance.in
Call Toll Free No : 1800 266 5844, website : www.libertyinsurance.in
IRDA of India registration number: 150 I 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?

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- 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?

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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]

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