CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED

Registered and Head Office: "Dare House", II floor, Old No.234, New No.2, NSC Bose Road, Chennai - 600 001. India

Cholamandalam MS
GENERAL INSURANCE

WORKMEN'S COMPENSATION INSURANCE CLAIM FORM

(The issuance of this form does not imply admission of liability.)

CLAIM NO: ______________________ **POLICY NO:** ______________________

1. Details of the Employer

(a). Name of the Policy Holder:
(b). Occupation:
(c). Address for communication/ Name of the contact person.
....
....
....

2. Details of Injured Person:

(a). Name : (b). Father's /Husband's name:
(c). Residential Address:
....
....
....
(d). Date of Birth / Age:
(e). Status of the Person: Permanent/Temporary/casual/Contractor worker.
(f). If injured person is Contractor's employee:
Give complete details of the contractor:

3. Details of Accident:

(a). Date & time of accident:
(b). Place of accident:
Is the place within your
work premises? If no, where?
(c). Date and time of reporting the
accident by the employee:
(d). To whom was reported.
(e). Please report the cause of any
variance in accident & reporting date
(f). On what exact work was injured
person engaged at the time of accident:

(g). How the accident occurred? Brief details.

(h). Was Injured Person under the influence of liquor/drugs at the time of accident :

(i). Were all safety rules/precautions observed at the time of accident :

(j). Name of the hospital Injured Person taken to :

(k). Date of Admission :

(l). Date of Discharge :

(m). Nature of injury :

(n). Did injured person actually cease work after accident and if so, on what date :

(o). Has injured person resumed duty since and, if so, on what date :

(p). What is the probable period of disablement:

(q). Was injured person free from physical infirmity at time of accident? If not, give particulars. :

(r) If the worker previously met with an accident, please give full particulars :

(s). Has the worker ever previously been awarded compensation by the Commissioner for workmen's compensation?

(t). Was injured person guilty of any misconduct or willful disobedience to orders or rules? If so, please give full particulars.

(u). State through whose neglect, if any, accident occurred :

(v). State names of any two persons who witnessed the accident. :

I/We hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect. I/We agree that if we have made already or if I/We make in any of my/our further statements in respect of the said incident any false or fraudulent declarations or suppress or conceal any material fact, the Policy shall be void and all rights of compensation in respect of the present or future accident shall be forfeited

Place:

Date :

Signature of Insured

TABLE OF WAGES

(Please fill in the Table of wages below as applicable)

1	2		3		4		5		6
Month & Year	Basic pay & D.A		Over time, Bonus and Dearness Allowance		Concession value of food-stuffs		Value of free quarters 10% basic wages		ABSENCE Give date of going on leave/beginning of period of absence and also date of subsequent resumption of work
	Rs.	P	Rs.	P	Rs.	P	Rs.	P	
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									

Total earnings in the period : From: To :
Average monthly wages:

If the worker's period of service was less than one month, give the average monthly wages of a workman employed on similar work, showing separately Basic Wages overtime, Dearness Allowance, Concession in value of food-stuffs Value of free quarters etc.

( ) Basic Wages…………………………………… Rs………………………
( ) Overtime……………………………………… Rs………………………
( ) Dearness Allowance…………………………… Rs………………………
( ) Concession in value
( ) of food – stuff………………………………… Rs………………………
( ) Value of free quarter (10% of Basic wages) Rs………………………

If the worker was a daily paid employee, give

(a). daily rate of wages. : Rs………………………

(b). daily allowances, if any, : Rs………………………

(c). number of days on an average that he/she would work in a month :…………….day.

Are free quarter provided?

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

Dated…………………20

Signature of the employer

Note: the details required are as per the workmen's compensation act.