Unv 2000 for 02-01

IFFCO-TOKIO

IFFCO-TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office : 34, Nehru place, New Delhi - 110 019
Surat Office : 1st Floor, House-A, 21st Century Business Centre, Nr. World trade Centre, Ring Road, Surat. Ph. : 2366145, 2337217

MEDICAL REPORT

1. Name of injured person _____
2. Age _____ 3. Sex _____
4. Full description of the nature and extent of injuries _____

_____

_____

_____

_____

5. Is the disablement for work :

   ** (a) total or partial ? _____

   (b) Solely the result of the Accident ?

   (c) Partly due to some previous Accident of illness ? If so to what extent

_____

6. How long is the disablement likely to continue _____
7. If the disablement is permanent, please state what is the percentage of loss of earnig capicity resuiting therefrom. (vide Schedule on the reverse) _____

_____

_____

8. Is any improvement possible ? if so, state what treatment you recommend and to what extent the disablement is likely to be reduced if it is carried out _____

_____

_____

9. Present general condition of Health and injury / ies of the injured person _____

_____

10. Does the examination point to the injured Person being :

    (a) Addicted to Drink or Drugs _____

    (b) Disposed to Malinger _____

11. Remarks _____

_____

_____

_____

_____

Signature _____

Qualifications _____

Address _____

_____

Date _____

P.T.O.

Please refer to section (2a) & (l) and Schedule 1 of the Workmen's Compensation Act reproduced on the reverse.

STATEMENT OF WAES

The object to this statement is to ascertain the injured person's average monthly earning, Please therefore observe the following instructions very carefully. failure to do so will entail unncessary correspondence and undue delay in the settlement of the claim.

1. If the injured person has been in the service during a continuous period (not broken by an absence of 14 or more consecuitive days of 12 months or more than enter the wages. etc., paid to him in each month during 12 months immediately preceding the accident.
2. if he has been in the service during a continuous period of less than 12 months but more than a month then enter the wages etc. paid to him in each month during such period immediately preceding the accident.
3. If he has been in the service during a continuous period of the less than one month, then enter the wages paid to another workman employed on similer woek during 12 months immediately preceding the accident i.e. accident to the workmen in respect of whom the claim is being submitted.
4. If you have no workman employed on similar work and for 12 months then enter the wages etc paid to the injured workman himself during whatever period of service he has put in immediately preceding the accident.
5. Please specify the period for which wages have been entered in this statement by mentioning the date of the begining of the period and the and of the period which should be the date prior to the date of accident.
6. Please do not mention merely the rate of wages, give full details as above.

MONTH	WAGES Rs.	Ps.	BONUS VALUE OF FREE QUARTERS & ANY OTHER ALLOWANCES ETC. Rs.	Ps.
	Total including all allowances			

(a) Were the above stated wages paid, or fallen due for payment to the injured person
if not, state to whom _____

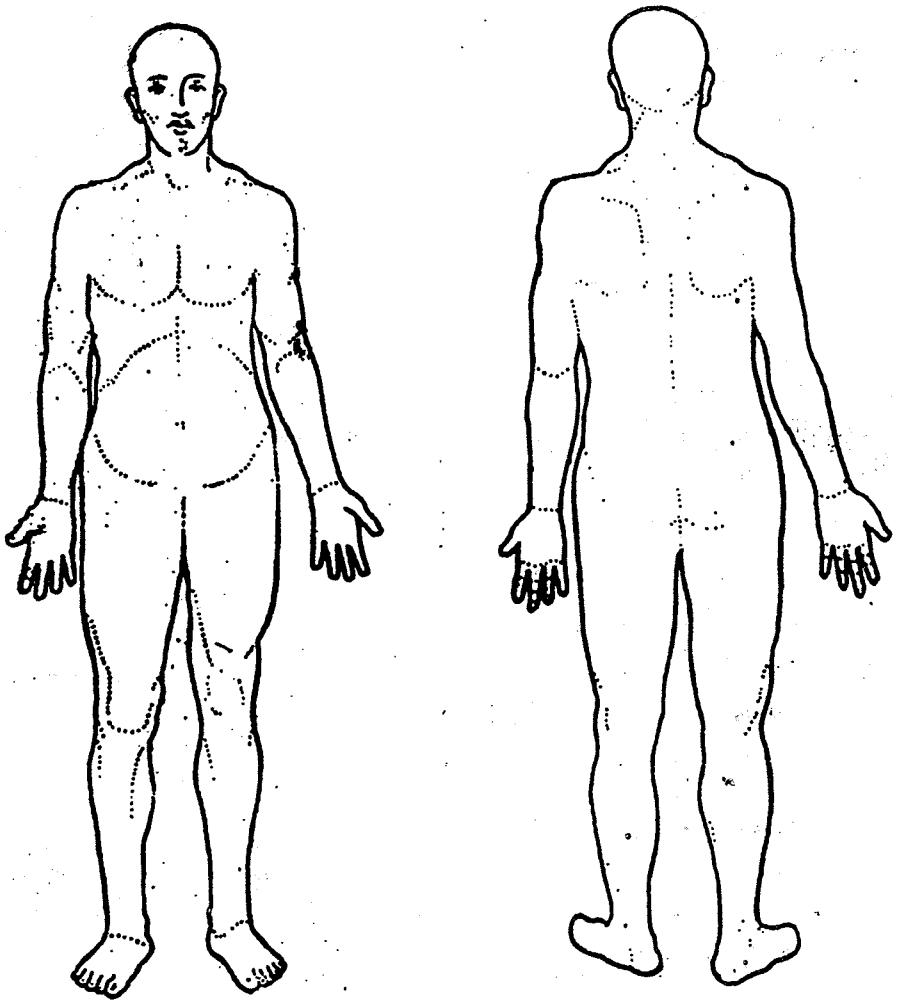
(b) Was the injured person absent from work at any at time during the above stated period, for 14 or more consecutive days ? _____
If so, give the following particulars :

Absent for _____ days from _____ to
Absent for _____ days from _____ to
Absent for _____ days from _____ to
Absent for _____ days from _____ to
Absent for _____ days from _____ to
Absent for _____ days from _____ to

Date _____ 20

Signature of the Employer

PLEASE, INDICATE CLEARLY ON BOTH FIGURES THE PRECISE EXTENT OF AMPUTATIONS, WOUNDS BURNS ETC WITH SUCH NOTES AS MAY BE NECESSARY TO MAKE THE MATTER **ABSOLUTELY CLEAR.**



Notes : _____

_____

_____

NOTE :

(a) COMPLETE and PERMANENT loss of any limb or member referred to in the Schedule shall be deemed to be the equivalent or the loss of that limb of member. For instance if a thumb is so completely ankylosed as to be incapable of performing its normal function there will be a 30% loss of earning capacity even thought thumb has not been ampututed.

(b) PARTIAL and PERMANENT loss of use of any lime or member, referred to in this Schedule shall be deemed to involve loss of earning capacity as is proportionate to the complete and permanent loss of use of such limb or member - For instance if a workman loses 50 % of the normal functions his hand he will suffer a 30% loss of earning capacity (i.e. 50% of 60%)

(c) In the case of an injury not specitied in this Schedule the loss of earning capacity shall be deemed to be such percentage of PERMANENT TOTAL disablement as is proportionate to the disablement permanently caused by injury. For instance if a workman sustains a Permanent injury, of his spine and is there by. incapacited to the extent of 35% for all work which he was capable of performing at the time of accident there will be a 35% loss of earning capacity.

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The issue of this from is not to be taken as an admission of liability not answering these questions Implies that the injured person is making or will make a claim.

If any details of information is not readily available please do not delay despatch of this report such particulars may be sent later.

All written communication should be forwarded to the company. Claim No.

THE EMPLOYER

1.	Name of Policyholder	
2.	Business	
3.	Address (and nerest Railway Station)	
4.	No. of Policy and Policy period	

THE INJURED PERSON

1. Name — Age _____ Sex _____
2. Religion of Caste — उम्र — लिंग
3. Local address

4.	Mofussil Address	
5.	Name and address of Father	
6.	State occupation in which the Injured Person is employed	
7.	Was the Injured person engaged in his occupation when the accident occurred ? If not state fully the nature of the work he was doing at the time of the accied ent.	
8.	Is the injured person in your direct employment ? if not give name and address of Contractor ?	
9.	When did the Injured person in your direct employmet ?	
10.	Name of the hospital taken to	
11.	In or out patient	
12.	State whether still in hospital or when dicharged	
13.	Has the injured person been medically examined if so, please send report if not, was free medical examination offered ?	
14.	State whether returned to work and if sohwhen ?	
15.	Are you satisfied that the injured person has met withabona-fied accident of employment ?	
16.	Is the injured person able to do partial work ?	
17.	What is the probable period of the disablement (approximation)	

THE ACCIDENT

1.	Date Time	Place
2.	Upon what date did you receive notice of accident and from whom ? if in writing Please attach it to this from	
3.	On what date did the injured person actully cease work ?	
4.	State how this accident occurred	
5.	If from machinery (a) Whether it was fenced or guarded ? (b) Was it being cleaned whilst in motion ?	
6.	What was the general nature of the Contract or work going ?	
7.	State nature of injury	
8.	State region injured	
9.	State whether right or left side	
10.	Was the injured person under the influcence of drink or drugs at the time of accident ?	
11.	Was he guilly of any misconduct or disobe-dience to orders or rules ? If so, please give full particulars.	
12.	State through whose neglect if occurred if any	
13.	State the names of any persons who Witnessed the accident.	

The above replies are correct to the best of my/our knowlede and belief.

Date _____ 20

Signature of Employer