WORK INJURY BENEFIT CLAIM FORM

To help us deal with your claim as quickly as possible PLEASE ANSWER ALL QUESTIONS ON THE CLAIM FORM FULLY AND CLEARLY, and sign and date the form.

(Remember, the more information you provide to us, the easier it will be to process your claim. If the spaces provided for answers are inadequate, please write on and attach a separate sheet of paper.)

Insured's Details

Full Name ____
Last Middle First

Policy Number ____

Address ______________________________ Telephone______________________

Email ______________________________ Fax ______________________

Claimant's Details

1. Name ______________________________

   Identity Card Number ______________________

2 Age__________ Height __________ Weight _______ Marital Status: Single ☐ Married ☐

3. Usual Occupation ______________________ Position ______________________

4. Was he in your direct employ or in that of a subcontractor? Yes ☐ No ☐

   If yes, please give details:

   ____

   ____

   Status of employment: Casual ☐ Permanent ☐

   If in your employ, how long has he been so employed? ______________________

   If a subcontractor, give the subcontractor's name and address:

   ____

   ____

5. Please let us know the employees monthly salary. Kshs. ______________________

Accident Details

1 Date of accident ______________ Time __________ Place ______________

2. State the precise nature of work he/she was doing at the time of the accident

   ____

   ____

   ____

   ____

3. How did the accident occur?

   ____

   ____

____

4. When did the injured employee cease work as a result of the accident? From ____________________ to ____________________
5. Was he performing a duty for which he was employed? Yes ☐ No ☐
6. Was he disobeying a rule or order? Yes ☐ No ☐

   If yes, please state how

   ____

   ____

   ____

7. Was the accident due to another person's negligence? Yes ☐ No ☐

   If yes, please give details:

   ____

   ____

   ____

8. a) Was the accident due to any defect for machinery or plant? Yes ☐ No ☐

   b) Had such defect been brought to your notice? Yes ☐ No ☐
9. Was the injured person under the influence of drugs or alcohhol at the time of the accident? Yes ☐ No ☐
10. Who was in charge?

    Name ____

    Job Title ____
11. a) Was the injured person suffering from any ill health or bodily defect at the time of the accident?Yes ☐ No ☐

    b) Were you aware of such ill health or defect? Yes ☐ No ☐
12. a) State fully the nature of the injuries received:

    ____

    ____

    ____

    b) State whether such injuries are likely to cause any permanent disability: Yes ☐ No ☐
13. a) Name and address of the injured Workman's Medical Attendant ______________________________________

    ____

    ____

b) If in hospital or nursing home, please provide the name and address

   ____

   ____

   ____

14. Were there any witnesses to the accident? If so, please give their names and addresses:

    Name ____

    Address ____

Attach a statement from witness

Declaration

I hereby certify that the above statement is a full and true account to the best of my knowledge

Signature ____

Name ____

Title ____

Date ____

Company Stamp

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