REAL INSURANCE COMPANY LIMITED
P O Box 40001 – 00100, GPO, Nairobi
Telephone No: 2712620 Fax: 2717888 / 2713831 Email: general@realinsurance.co.ke Website: www.realinsurance.co.ke

WORKMEN'S COMPENSATION ACCIDENT CLAIM FORM

Agency: Policy No: Claim No:

1.	(a) Employer's name	
	(b) Address	
	(c) Business	
2.	(a) Date, time and place of accident	
	(b) When was the accident first reported to you and by whom?.....	
	(c) Names of witnesses.....	
3.	(a) Name of injured person.....	
	(b) Usual occupation.....	
	(c) When did he enter your service?.....	
	(d) Was he in your direct employ, or in that of a sub-contractor? If the latter, state the name and address of the sub-contractor	
4.	State precisely what he was doing, and how the accident occurred (full information) (If the accident was due to any defect in machinery or scaffolding, please give details)	(Please continue on back of form if necessary)
5.	(a) Was he performing a duty for which he was employed?.....	
	(b) Was he obeying any rule or order?.....	
	(c) Who was in charge?	
	(d) Was accident due to another person's negligence? If so, give full particulars	
6	Nature and extent of injury as evident at time of accident	
7	Is there anything else regarding the accident or the injured person which the Company should know?	
8	Have you any other insurance or indemnity covering accidents to your employees? If so, please give particulars	
9	Please give details of the injured person's total monthly earnings at date of accident	Wages..... Shs ..... Per month Rations ..... Shs ..... " " Housing ..... Shs ..... " " Other earnings or allowances Shs ..... " " **Total .....** Shs ..... " "

Date ..... Employer's Signature: .....

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