TOKIO MARINE
INSURANCE GROUP

Claim Form

Workmen's Compensation Insurance

Claim No. _____ Policy No: _____

N.B.
1. Full particulars of the accident are to be furnished by the Employer.
2. The giving of the undermentioned information does not imply that the injured person is making, or will make, a claim.
3. This form is sent without prejudice to the terms of the policy.
4. This form is to be completed and forwarded without delay. Any details of information not readily available may be supplied as soon as obtained.
5. All written communications received by the Employer concerning the accident to the employee should be forwared at once to the Company.

The Employer

Name of Policyholder _____

Business Address _____

Poscode _____

Telephone No. _____

The Injured Person

Name _____ ☐ Male ☐ Female

Age _____ I/C No. _____ Nationality _____

Local Address _____

_____

Domicile _____

When did the injured person enter your service? _____

Work in which the injured person is usually employed _____ Class No. _____

Was the injured person engaged in the above work
when the accident occured? _____

Is the injured person, your direct employee,
contractor's employee or a sub-contractor? _____

Name of Hospital taken to
In or out-patient
State whether still in hospital, or when discharge _____

Has the injured person been medically examined?
If so, please send report. If not, was free medical examination offered? _____

State whether returned to work, and if so, when? _____

Are your satisfied the injured person has met with a
bonafide accident arising out of his employment? _____

Is the injured person able to do partial work? _____

What is the probable period of disablement (approximate)?
Please submit medical chit confirming the period of disablement. _____

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The Accident

As regards the accident, please state

Date D D M M Y Y Y Y Time _____ Place _____

On what date did you receive notice of accident and from whom? If in writing, please attach to this form.

_____

State cause of accident; and if from machinery of gearing

(a) Whether it was fenced or guarded _____

(b) Was it being cleaned whilst in motion _____

What was the general nature of the contract or work going on? _____

State nature of injury _____

State regions injury _____

State right or left side _____

Was the injured worker under the influence of alcohol or drugs at the time of accident? ☐ Yes ☐ No

Was he guilty of any misconduct or disobedience to orders or rules ☐ Yes ☐ No

If so, please give full particulars _____

State through whose neglect the accident occured, if any _____

State the name of any person who witnessed the accident _____

Has the accident been reported to the Commissioner and Police?
State when and where

_____

Additional particulars for FATAL CASES only

Has the deceased any dependants? State names, address and relationship

_____

Will an enquiry into the death be held? If so, please supply a copy of the notes as soon as possible.
If no enquiry will be held, a Medical or the Post-Mortem Certificate is required

_____

Statement of wages of the Injured Person earned IN THE PRESENT EMPLOYMENT for the six months immediately prior to the date of this Accident, or wages earned during such short period as he may have been in the Employer's service, stating the date on which he was engaged.

(Note: The object of this form is to EXACT MONTHLY EARNINGS of the injured person. It is essential that it should be carefully and correctly fill in. If THE INJURED PERSON HAS BEEN ABSENT FROM WORK AT ANY TIME during the period of his employment, please state the period and the cause.)

YEAR	MONTH	WAGE	Bonus, Value of Free Quarters & any other Allowances & c.
		RM	RM
	TOTAL		
		Total including allowance	

Declaration

I/We hereby declare the foregoing answers to be true in every respect to the best of my/our knowledge and belief that no information or particulars have been suppressed.

_____
Signature of Employer

Name: _____

NRIC: _____ Date: _____

_____
Company Stamp (if applicable)

Designation: _____