IFFCO-TOKIO GENERAL INSURANCE CO. LTD

Regd. Office: IFFCO Sadan, C-1, Distt. Centre, Saket, New Delhi-110017

ADDRESS OF POLICY ISSUING OFFICE

Claim No.: _____ **Date of Issue:** _____

ALL IN ONE HOME PROTECTOR POLICY

UIN: IRDAN106RP0064V01201819

SECTION 11 B - EMPLOYEES COMPENSATION INSURANCE CLAIM FORM

- Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form should not be construed as admission of Liability.
- Please fill in all the blanks and give complete details of information asked for. In case space provided is found insufficient, a separate sheet may kindly be annexed.
- Please return this form, duly filled & signed, within 7 days, from the date of occurrence. If any detail of information is not readily available PLEASE DO NOT DELAY DESPATCH of this form but send supplementary advice later.
- These questions are to be answered whether or not a claim from the injured person has been made or is anticipated.

PARTICULARS OF ACCIDENT TO BE FURNISHED BY THE EMPLOYER

PART – I THE EMPLOYER	
Name of Policy holder	
Policy Number	
Address	
District	
State & Pin Code	
PART – II PARTICULARS OF INJURED PERSON	
Name	
Religion or Caste	
Local Address	
Permanent Address	
Occupation in which injured person is employed	

On what work was injured person engaged at the time of accident?	
Was the injured person actually working when the accident occurred?	
Is injured person in your direct employment? (if not give name & address of Contractor and Nature of Contract)	
Name of the Hospital taken to	
State whether still in Hospital, or when discharged	

State nature of injury, body parts injured and whether left or right	
Did person actually cease work and if so, on what date ?	
Has injured person resumed duty since and if so, on what date?	
What is the probable period of disablement? (approximate)	
Was the injured person free from physical infirmity at the time of accident? If not, give particulars	
PART – III PARTICULARS OF ACCIDENT	
Date of Accident	
Did the accident occur actually within your home premises? If not, where did it occur?	
On what date did you receive notice of accident and from whom? If in writing please attach to this form	
Are you satisfied that injured person met with a bonafide accident of employment	
How exactly did the accident occur?	
If accident due to machinery, state: (a) Whether it was fenced or guarded (b) Was it being cleaned whilst in motion	
Was injured person under the influence of alcohol or drugs at the time of the accident?	
Was he guilty of misconduct or disobedience to orders or rules? If so, please give full particulars	
State through whose neglect, if any, it occurred	
State the names of any two persons who witnessed the accident	
Give names of overlooker or persons in Superintendence.	

I/We, declare that all statements made on this form are true to the best of my/our knowledge and belief.

I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

Name: **Signature:** **Date:**

STATEMENT OF INJURED PERSON'S EARNINGS

Statement of wages, which have fallen due for payment to _____
in the employment of _____ for 12 months prior to the date of his accident, or wages earned during such shorter period as he may have been in the employer's service.

Note: The object of this part of the form is to ascertain the extra average monthly earning of the injured person. It is essential that it should be carefully and correctly filled in. If the injured person has been in service for less than 12 months his date of entry into service is essential. So also if he was absent continuously for more than 14 days (within 12 months) between the date of his entry into service and that of accident, then the period of service should be counted from the date of resumption of duty.

Date on which injured person first entered service: _dd/mm/yyyy_____
Date on which the injured person resumed duty after a continuous absence of more than 14 days: _dd/mm/yyyy_____

Month & Year	Wages Earned (Including Overtime)		Value of bonus, food subsidy, if any, free quarters and any other allowance, etc.		Absences
1.	Rs.	P	Rs.	P	
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
Total earning in the period from_____ to _____					
Total earnings, including all allowances					
Monthly average wages					

SPECIAL NOTE :

1. If the employee's period of service was less than one month, give the average monthly wages of an employee employed on similar work Rs. _____.
2. Please state the exact nature of the allowance and / or bonus.
3. In the column "absence", please give the date of going on leave or beginning of period of absence and also date of subsequent resumption of work.

I/We, the undersigned, confirm that above given details are true & correct to the best of my/our knowledge.

Date: _____

Signature of Employer

(add below any additional information available regarding the accident)

_____

Signature of Employer