# WORKERS' COMPENSATION CLAIM FORM

. **IMPORTANT REMINDER**

- **It is most important that all questions are answered. If not applicable, write "n/a.**
- **The issue of this claim form is not an admission of liability by PAG**
- **If there is insufficient space or further comment on any are is considered necessary, please use additional pages.**

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. **EMPLOYERS DETAILS**

1 Name of Employer……………………………… Nature of Business………………………………………
Address of Employer……………………………………………………………………………………..
…………………………………………………………………………………………………………
Tel No………………………Fax No………………………Email Address…………………………………

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**DETAIL OF ACCIDENT**

1. Day of week………………………. Date……………………………………Time……………………am/pm
2. Sate exact location where injury was sustained……………………………………………………………...
3. Did the injured person give notice of injury? (Yes/No) To whom was it given?............................................

**Note**: **If the worker failed to give notice of the injury as soon as practicable after its happening, he/she is required to provide a written statement explaining and showing reasonable cause why notice of injury was not give.**

a. When was given?...................am/pm Date………….. Verbally or in writing………………………...
b. Give the names of person or persons who were actual eye witnesses of the injury……………………
………………………………………………………………………………………………………….
…………………………………………………………………………………………………………

4 Describe fully the circumstances leading to the accident…………………………………………………
…………………………………………………………………………………………………………….
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………
…………………………………………………………………………………………………………….

5 What was the nature of injury?.......................................................................................................................

6. if the injury was caused by any person or persons not in your employment, please advise full name and address of those concerned………………………………………………………………………………….
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**INJURED EMPLOYEES DETAILS**

1. Name of the injured……………………………….. Address…………………………………………………
……………………… Occupation…………………….. How long in your employment……………………..

2 Nature of business in which injured was employed in……………………………………………………

3 State the operation at which the worker was engaged at the time of accident…………………………………
……………………………………………………………………………………………………………..

4 a. Was injury sustained in the course of workers employment with you?..............................................
b. Did injury arise out of workers employment with you?.........................................................................
c Was the worker in the service of any other employer at that time?......................................................

5. was the worker injured while doing something which he/she was not part of his/her particular employment To do , or was he/she injured at a place or part of the works where he/she was not required to be by his/her Particular employment?...................................................................................................................
……………………………………………………………………………………………………………..
……………………………………………………………………………………………………………..

6 Schedule

| Age | Married/Single | No of days worked/week | Average weekly earning | Date/time not able to work | Length of time disabled |
|---|---|---|---|---|---|
| | | | | | |

7 Is the injured person related to you?.............. If so, what is the relationship and does he or she reside with you?.........................................................................................................................................................

8 State clearly if injured person is casual, permanent or working under contract………………………………..
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**COMPENSATION DETAILS**

1 a Has the injured person returned to work? Yes/No
b. Id so, when?.........................................................................................................................................

2 Is compensation being claimed or received from any other insurer?..........................................................
……………………………………………………………………………………………………………
……………………………………………………………………………………………………………

3 Was the injured person free from physical disability at the time of the accident?.......................................

4 Are you aware whether the worker has ever previously suffered from a similar injury?.................................

5 Was the part affected by this accident quite normal before the accident? Yes/No
If "NO" please give full details……………………………………………………………………………
……………………………………………………………………………………………………………..
……………………………………………………………………………………………………………..

6 Would such physical disability have contributed to this accident?...............................................................

7 If the worker has received any medical, surgical or hospital treatment, please state under which hospital and forward medical receipts if available
Name of hospital………………….. Whether In-patient/Out-patient…………………………………………

Name of doctor………………………….. Address………………………………Fax No………………..
Tel No……………………………. Email Address………………………………………………………

8 **Details of dependents (to be completed after consultation with employee)**

| Names | Date of Birth | Relationship | State whether wholly or partially dependent |
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**DECLARATION**

I/We declared that:

1. the information and answers given above are correct to the best of my/our knowledge and belief
2. I/We understand the claim may be refused or reduced if information is withheld

**Signature of Employer…………………………………………… Date………………..………………..**