GALLOWAY'S
INSURANCE CONSULTANCY AGENCIES

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/she enter your service? _____

(d) Was he/she 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/she was doing, and how the accident occurred.

(Full information. If the accident was due to any defect in machinery or

scaffolding, please give details. Continue on back of form if necessary):

_____

5. (a) Was he/she performing a duty for which he/she was employed? _____

(b) Was he/she obeying any rule or order? _____

(c) Who was in charge? _____

(d) Was the 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 should be recorded? _____

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: Kshs _____ Per month
- Rations: Kshs _____ Per month
- Housing: Kshs _____ Per month
- Other Allowance: Kshs _____ Per month
- **Total:** Kshs _____ Per month

Date: _____ Employer's Signature: _____
