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WORK INJURY BENEFIT CLAIM FORM

- This report is to be completed by the Employer in case of injury to or Death of a Workman.
- If any detail of information is not available immediately, please do not delay to dispatch this report. Such particulars should be sent later.
- Subject to the provisions of the WIBA an employer is required to report an accident to the Director of Occupational Health and Safety either verbally or in writing within 24 hours in the case of a Fatal injury and within seven days after having recieved notice of an accident or having learned that an employee has been injured in an accident. This includes any accident reported by an employee to an employer and the employee alleges that the same arose out of or in the course of employment irrespective of the opinion of the employer.
- All documents recieved from the employee should be submitted to the Director within 7 days of receipt.
- All written communication should be forwarded to the Company.
- An employer / insurer against whom a claim for compensation is lodged by the Director under section 26 sub-section 4 of WIBA shall settle the claim within 90 days of lodging the claim.

1. **THE EMPLOYER**

   a) Name: .....

   b) Address: .....

   c) Industry or Business: .....

   d) Policy No.: ..... Commencement date: ..... Expiry: .....

   e) Are you registered with the Director of Occupational Health & Safety? (YES/ NO) ..... If YES Reg. No.: .....

2. **THE WORKMAN INVOLVED IN EMPLOYMENT INJURY**

   a) Name: .....

   b) Address (Home and Permanent): .....

   c) Sex: ..... Age: .....

   d) I.D. No.: ..... Occupation of injured person at time of accident: .....

   e) Workman's Job Description.: .....

   f) Was he a Casual or Permanent or Under Contract: .....

   g) If Under Contract, name of the Contractor: ..... (Kindly attach copy of the Contract)

   h) Academic / Professional qualification / Technical or Trade Test: .....

   i) Was the injured workman in your direct employment? (YES / NO): ..... If not, was he working at the place of the accident under the employment of a contractor or others?: .....

   State details.: .....

   .....

   .....

   .....

   j) When did the injured person enter your service?: .....

   k) Monthly or daily earnings at the time of the accident : .....

   l) Has the workman filed suit? (YES / NO) ..... Has the workman previously filed suit against you? (YES / NO): .....

   If Yes, give details of suit/s .....

   m) Is the injured person still in employment? If not state date when he / she ceased work: .....

3. **THE ACCIDENT**

   a) Date: ..... Time: ..... Place: .....

   b) Upon what date and time did you receive notice of the accident and from whom: .....

c) Has the injury been reported to the Director of occupational Health and Safety? YES / NO: ..... If Yes Date reported .....
and how..... (submit documentary evidence with this form)

d) Cause of the Accident: .....

e) Was the workman recorded on duty at your workplace on the injury date.: .....

f) What duty was the workman assigned at the time of the injury: .....

If injury caused by machinery;

1. State name of machine & part causing the injury?: .....
2. Was it fenced or guarded?: .....
3. Was the machine being cleaned?: .....
4. What was the general nature of work going on?: .....
5. Was it in motion when the injury occurred?: .....
6. Who was responsible for switching it on or off?: .....
7. Who switched it on?: .....
8. His address?: .....
9. His Permanent / Home address if different from above?: .....
10. State exactly what the injured person was doing when he got injured?: .....
.....
.....

If injury not caused by machinery (e.g. Fire, a fall, carrying heavy objects) name the cause and give a brief description of how the workman got injured : .....
.....
.....

Was the injured person under the influence of alcohol / any drink or drugs at the time of the accident?: .....

4. THE INJURY

a) Was it fatal? : ..... if fatal give the names of all dependants of the deceased workman if known .....
.....
.....

b) Have the dependants informed the Director of Occupational health and Safety? (YES / NO): ..... If Yes when .....
and how .....
Particulars of injury (as certified by the Hospital / Company doctor) .....
..... are the injuries visible?: .....

c) Is the complaint of an occupational disease YES / NO ..... If Yes, briefly describe when first diagnosed .....

d) Was the claimant medically examined prior to commencing employment? (YES / NO): .....

e) State the probable period of disablement: .....

f) Name the Hospital / Dispensary / Private Clinic where he has been treated following the accident: .....

g) Whether admitted (YES / NO): ..... Date when first treated: .....

h) Date of admission: ..... Date of discharge: .....

i) Attendance as out-patient prior to and/or subsequent to hospitalization: From ..... To .....
Was there a doctor's medical report? (YES /NO): ..... (If Yes please provide a copy of this report)

j) Amount expended on treatment: .....

k) Who paid for it : .....

l) Was the injury recorded on an occurence book / injury register? (YES / NO): ..... (If Yes please attach copy)

m) Was there DOSH 1 form filled? (YES / NO): ..... (If Yes please attach copy)

n) Has he/she resumed work? (YES / NO): ..... When: .....

5. **OBSERVANCE OF INSTRUCTIONS**

a) Were there any standing instructions/notices on how to do the assigned work? (YES/ NO): .....

Briefly explain: .....

.....

.....

b) Was the workman guilty of any misconduct or disobedience to such instructions or other orders or rules?(YES/ NO): .....

If so please give details: .....

c) Was the injured under the influence of drink or drugs athe time of the accident?: .....

d) Whether the injured workman was provided with protective clothing/guards e.g. gloves, gum boots, helmets, goggles etc? (YES/ NO): .....

If Yes, state the items provided ..... and was the workman utilizing the gear at the time of injury ..... if not, why? ..... Date of supply: .....

Did the workman sign for the gear? (YES/ NO): ..... If yes, please attach a copy of the signed register.

e) Was the workman found without the protective clothing/guards at the time of the accident? (YES/ NO): ..... If No, give reasons why .....

f) Had his immediate supervisor brought to the attention of the injured workman the necessity of wearing protective clothing/guards when the former saw the latter without these guards at the time of commencement of his work but before the occurrence on the date of the accident?:

.....

g) State through whose neglect this injury occurred: .....

6. State the names, addresses (Permanent & Home) of the persons who witnessed the accident:

a) .....

.....

b) .....

.....

c) .....

.....

7. Brief statement/s from the above named persons who witnessed the accident when it occurred:

a) .....

.....

Name: ..... Designation: .....

Date: ..... Signature: .....

b) .....

.....

Name: ..... Designation: .....

Date: ..... Signature: .....

c) .....

.....

Name: ..... Designation: .....

Date: ..... Signature: .....

The above details are factual to the best of my/our knowledge, information and belief.

(THE BELOW PART MUST BE COMPLETED) (Please stamp here using the Compny's authorized stamp)

Date: .....

Name: ..... Signature of Employer: .....

Designation: .....

STATEMENT OF WAGES

The object of this statement is to ascertain the injured person's average monthly earning. Please therefore observe the following instructions very carefully. failure to do so will entail unnecessary correspondence and cause undue delay in the settlement of the claim:-

1. If the injured person has been in the Employer's service during a continuous period of more than one month immediately preceding the accident, the wages that have been paid or fallen due for payment, to him/her in each month of such period (not exceeding twelve preceding months in all), must be entered in the statement.
2. If the injured person has been in the Employer's service for less then a month, there must be entered in the statement the wages paid to another workman employed on the same kind of work by the Employer during the twelve months immediately preceding the accident.

MONTH		WAGES Shs.	Cts.	BONUS, VALUE OF FREE QUARTERS & ANY OTHER ALLOWANCES. Shs.	Cts.
TOTAL					
		Total including Allowances			

a) Were the above stated wages paid, or fallen due for payment, to the injured person?

If not, state to whom? _____

b) Was the injured person absent from work at any time, during the above stated period, for 114 or more consecutive days?

_____

c) If so, give the following particulars:-

Absent for _____ days from _____ to _____