Industrial and General Insurance Plc

Plot 741, Adeola Hopewell Street, V/Island, Lagos.
P.M.B. 80181, Victoria Island, Lagos.
Tel: +234-1- 6215010-4, Fax: +234-1-2621146
Website: www.iginigeria.com, E-mail: info@iginigeria.com

WORKMEN'S COMPENSATION ACCIDENT REPORT FORM

The Company does not admit Liability by the issue of this Form

Please answer all questions fully and return forms without delay.

Policy No _____ Claim No _____

Agency _____

Insured _____

Contact Address _____ State _____

Postal Address _____ State _____

Occupation _____

Telephone _____ Mobile _____ Email _____

Last premium Date: _____

In connection with what trade or business did you employ the injured person? _____

Are you insured elsewhere against this risks? If so, give name of Company. _____

PARTICULARS OF INJURED PERSON

Name _____ _____ _____

Surname *Firstname* *MIddlename*

Occupation _____

Date of Birth _____ Married or Single _____

Number of children under 15 _____

Is (s) he related to you? If so, state relationship _____ (s) he reside with you? _____

(a) Is (s) he is your direct employ? _____

(b) Is (s) he in your sole employ? _____

(c) Since what date? _____

If in the service of a sub-contractor, give the name and address of the Sub-Contractor

_____

Name *Address*

Is (s) he an insured person under the national Health Insurance Act?

Yes ☐ No ☐

If so, state Name and address of Approved Society and Membership Number

THE ACCIDENT

State the Date, Hour and Place of Occurrence Date Hour Place

State when Injured Employee ceased work Date Hour Place

Describe fully how the accident happened

State precisely the duties of the injured Employee when the accident occurred.

What was the general nature of the work going on?

What machinery was in use in connection with the work?

(a) Give date the injured person first reported the accident?

(b) To whom was it reported?

Did the accident occur during his/her working hours? Yes No

Was (s) he sober? Yes No

(a) Was (s) he guilty of any misconduct or disobedient to orders? Yes No

(b) If so, give full particulars

(a) Was the accident due to negligence upon the part of any person? Yes No

(b) If Yes, give name and state whether such person is in your direct employ?

Name

Names and addresses of any witnesses of the accident

THE INJURY-

State very fully the nature and extent of the Injury N.B – If to a limb, state whether right or left

(a)Is the Injured Employee able to attend to any portion of his/her work? Yes No

What is the likely duration of incapacity?

Where was (s) he taken after the accident?

Where is (s) he now?

Name and address of Doctor in attendance

GENERAL INFORMATION

Give all such other details respecting the Accident and the Injured Employee as would be of assistance to the company.

STATEMENT OF WAGES *earned by the injured workman for twelve months prior to the date of the Accident or for such shorter period as he/she may have been in the Employer's service.*

NOTE: Please state reason for any period of absence from work

WEEK ENDED	WAGES		WEEK ENDED	WAGES		WEEK ENDED	WAGES	
1			19			37		
2			20			38		
3			21			39		
4			22			40		
5			23			41		
6			24			42		
7			25			43		
8			26			44		
9			27			45		
10			28			46		
11			29			47		
12			30			48		
13			31			49		
14			32			50		
15			33			51		
16			34			52		
17			35					
18			36					
			Forward			Total amount earned in weeks		

Average Weekly Earnings_____

State if any consideration other than cash wages is received by injured person-

(a) Nature of consideration

(b) Cash Value per week

I/We the undersigned Policy holder hereby declare that the above statements and facts are true and that I/we have not withheld from the Company any information within my/our knowledge connected with the claim.

Signature of Policy Holder _____ *Date*_____

Please enclose medical certificate, if available