Universal Sompo General Insurance
Suraksha, Hamesha Aapke Saath

EMPLOYEES COMPENSATION INSURANCE POLICY

CLAIM FORM

Claim No._____

All questions must be answered fully. If there is insufficient space, kindly use a separate sheet which can be attached to this form.

The issue or acceptance of this form is not to be construed as an admission of liability by USGI.

A. The Insured Risk Code (For office use)

1. Name _____
2. Address_____
3. Tel No. Office_____ Mobile_____ Email _____
4. Contact name _____ Mobile _____ Email _____

B. Policy Details

Policy No. _____ Period of Insurance ____/____/_____ to _____/_____/_____

C. Injured Person Details

Name _____

Age_____

Local Address _____

Native place address _____

Father's name _____

Occupation for which injured was employed _____

Nature/description of job being performed by injured person at the time of accident

_____

Is the injured person directly under your employment? Yes □ No □

If not, for whom and in what capacity the injured was working at the time of accident

_____

D. Details of Accident

Date of accident _____/_____/_____ Time of accident_____am/pm

Place of accident (exact premises/address) _____

When did you receive intimation of accident and from whom _____

How did the accident occur _____

Are you satisfied that the accident occurred in the course of and arising out of employment? **Yes** □ **No** □

Was the injured person under the influence of drugs or drinks at the time of accident? **Yes** ☐ **No** ☐

Was the injured person guilty of misconduct or disobedience of orders/rules? **Yes** ☐ **No** ☐

If yes, provide details_____

Names of witnesses _____

Is the accident reported to Police or any other authority? **Yes** ☐ **No** ☐

If yes, attach a copy of the report.

E. Details of Injury & Treatment

Nature of injury _____

Parts/Regions of body affected_____

Whether left side or right side _____

Name & Address of hospital treated at _____

Whether still in hospital or discharged _____

What is the medical opinion on nature and extent of disablement? _____

_____

Whether returned to work? **Yes** ☐ **No** ☐

If not, likely date of resumption of duty _____/_____/_____

What is the probable period of disablement? _____

_____

Declaration

1. I/We agree to provide additional information to the Company if required. I/We are the above insured, and I/We guarantee the truthfulness of the above statement in every respect, to the best of my/our knowledge and belief, and if I/We have made any false or fraudulent statement, or have suppressed or concealed any material facts, the policy will be cancelled and all rights in respect of past or future claims will be reserved.

2. I/We understand that the Company reserves the right to verify & obtain my identity, address, facts and documents relating to the policy and claim with rating agencies, third parties or service providers.

3. I/We have read and understood the privacy policy of the Company at www.universalsompo.com and I/We unconditionally agree and bind myself/ourselves to all the terms and conditions of your privacy policy as amended from time to time.

4. I/We have received a list of documents with this claim form and have understood all the requirements to be fulfilled for scrutiny and processing of this claim and the Company shall not be responsible for any delay in scrutiny and processing/settlement of claim due to claimant's non-fulfilment of requirements including non-submission of the required documents/information as mentioned above.

5. I/We declare that the details of all persons having an interest in the property in respect of which the claim is being made are provided as per the proposal form or by way of an endorsement in the policy. Except as disclosed in this claim form, no claim for the same or similar loss has been made or lodged with any other insurance company.

6. I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof/ bank details as well as the identity/address proof of the Insured / Beneficial Owner through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

Signature of authorized signatory

Date: _____/_____/_____

Company Seal

Documents to be submitted (as relevant to the specific claim) along with claim form:

- FIR
- Medical certificate/treatment documents
- Fitness Certificate
- Death certificate
- Post Mortem Certificate
- Age proof
- Statement of witness
- Summons from WC Commissioner
- Report to Inspector of Labour
- Petition

This is an Internal document.

STATEMENT OF WAGES

The purpose of this statement is to ascertain the injured person's average monthly earnings, hence provide the details carefully and accurately.

Please provide details of injured person's wages for the last 12 months immediately preceding the accident or for shorter period in case employed for less than 12 months. In case he has been employed for less than 1 month, then enter the wages paid to another workman employed for similar work during last 12 months. In case there is no workman engaged in similar work, enter the wages paid to injured employee himself during whatever period he has been in your employment. If injured person is a daily wager, give the daily rate of wages and average number of days the injured person would have worked in a month.

Month and year (Fill in specific dates for each month)	Wages	Overtime Allowance	Bonus	Value of food subsidy, free quarters, any other allowance	Period of absence
__/__/___ to ___/___/___					__/__/___ to ___/___/___

The above statement of wages is accurate to the best of my/our knowledge and belief.

Signature of employer/authorized signatory Date: _____/_____/_____

Company Seal

This is an Internal document.