INVESCO
INVESCO ASSURANCE COMPANY LTD
"Moving Ahead With Confidence"

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WORK INJURY BENEFITS ACT

The issue of this form is not to be taken as admission of liability not answering these questions implies that the injured person is making, or will make a claim.

If any detail of information is not readily available, please do not delay dispatch of this report. Such particulars may be sent later. All written communications should be forwarded to the company.

THE EMPLOYER

1. Name of Policy holder……………………………………………………………………
2. Business………………………………………………………………………………………
3. Address………………………………………………………………………………………
4. Policy Number………………………………………………………………………………

THE INJURED PERSON

1. Name……………………………………………………………………………………………
2. Religion or Caste…………………………………………………………………………
3. Local address………………………………………………………………………………
4. Permanent Address………………………………………………………………………
5. State occupation in which the injured person is employed………………………………………………………………………………………
6. Was the injured person engaged in this occupation when the accident occurred? If not state fully the nature of the work he was doing at the time of the accident……………………………………………………………………………………
……………………………………………………………………………………………………
7. Is the injured person in your direct employment? If not give name and address of Contractor…………………………………………………………………………………
……………………………………………………………………………………………………
8. When did the injured person enter your service………………………………………
9. Name of hospital taken to……………………………………………………………
10. In or Out Patient…………………………………………………………………………
11. State whether still in hospital, or when discharged…………………………………
……………………………………………………………………………………………………
12. Has the injured person been medically examined? If so, please send report. If not, was free medical examination offered………………………………………………………………………………………
……………………………………………………………………………………………………
13. State whether returned to work if so when……………………………………………
14. Are you satisfied the injured person has met with a bona-fide accident of employment?…………………………………………………………………………………

15.Is the injured person able to partial work……………………………………………

16.What is the probable period of the disablement (approximate)………………………

THE ACCIDENT

1. Date…………… .....Time……………… ..Place………………………
   ……………………… ..
2. Upon what date did you receive notice of accident and from whom? If in writing please a t t a ch t o t hi s f o rm …………………
   ……………………………………………….
3. On what date did the injured person actually cease work?……………………………

   …………………………………. ……………………………………………………
………
4. State cause o f accident and if f rom machiner y or g earing…………………………… .
   a) Whether it was fenced or guarded…………………………………………… . b) Was it being cleared whi lst in motion?…………………………………… ……..
5. What was the genera l nature o f the contract or work going on…………………
   ……

   ……………………………………………………………………………………………
   .

6. State nature of injury……………………………………………………………
   .
7. State regions injure d…………………………………………………………
   ……..
8. Was the injured person under the influence of alcohol or drugs at the t ime of the a ccident………………….. ………………….. ………………….. ……………
   …… ..
9. Was he/ she guilty of any misconduct or disobedience to orders of rules ? If so

   please give full

   particulars………………………………………………………………………………
   …………………………………………………………………………………… …….

10.State through whose neglect it o ccurred, if any…………………………………..
..

11. State the names of any pers on who witnessed the accident……………………..
..

....

...

12.State the name of the immediate supervisor...

13.What prot ective wear was provi ded t o the worker.. .

14.What safety precautions were given or displayed...

Date................................20......   ....

Signature of Employer

STATE MENT OF WAGES

1. The objective of this sta tement is t o ascertain the injured person 's average monthly ea rning. Please t heref ore ob serve the following instructions very carefully. Failure to do so will result in unnecessary correspondence and cause undue delay in the settlement of the claim:-
2. If the injured person has been in the Employers service for less than one month, then there must be entered in the statement the wages to be paid to another workman employed on the same kind of work by the employer during the twelve months immediately preceding the accident.