

DOMINION INSURANCE LIMITED

Civic House
P.O. Box 14468, Suva.

WORKMEN'S COMPENSATION CLAIM FORM

REFERENCE POLICY No.

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CLAIM No.

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Employer

1. Name: _____

2. Postal address: _____

3. Nature or type of business: _____

4. Place of accident: _____

Injured Worker

5. Name - Mr/Mrs/Miss _____
(Full name)

6. Occupation: _____

7. AGE last birthday: _____ years.
(IMPORTANT: If not known exactly, please state as near as possible).

8. Whether married, single, widowed, etc. (state): _____

9. Number of dependent children: _____

10. Number of hours worked on day or shift at time of accident (including hours before meal interval, if any): _____

11. Date of accident: _____ Time: _____ am/ _____ pm

12. Did worker continue working after accident? YES/NO.
if yes, give time and date he ceased work; a.m. _____ p.m. _____ / ____ / ____ 19 ____

13. Has worker resumed work? YES/NO. If so, on what date? _____ / ____ / ____ 19 ____
If not, how long is worker likely to be away from work? _____

Description of Accident

14. What was the worker doing when the accident occurred? _____

15. What happened and how did it happen? _____

16. Was the injury caused by misconduct or disobedience of rules or orders? Yes/No.

17. Was the injury caused by anyone not employed by; you - if yes, whom? _____

18. Specify actual cause or contributing factor which was directly responsible for the ACCIDENT occurring (e.g the condition of the floor, inadequate lighting, not wearing safety glasses.)

19. Name the item of equipment, object, etc.(and part thereof) which inflicted the INJURY (E.g. Electric hand tool, mahine lathe, band saw blade, power press.)

Injury Details

20. Nature of injury: _____

21. Part of body affected: _____
(Describe in detail e.g. left lower leg)

22. Doctor or hospital attended: _____

23. Medical Certificate attached - YES/NO. (If not attached, please forward as soon as possible)

Other Details

24. Was accident reported by worker? YES/NO. If so, to whom? _____
_____ and on what date? _____ at what time? _____

25. Was there in your opinion any negligence on behalf of the injured worker? If yes give reasons

26. Name and position of person in immediate charge: _____

27. Names(s) of witness(es): _____

Employer-Worker Relationship

28. Is worker a member of your family? If so, state relationship: _____

29. Was the worker in your employ, and on your pay sheets, and actually working for you in the course of his employment at the time of the accident? YES/NO.

If yes, how long have you employed him? * _____ years _____ months.

30. Was he working for other person who had agreed to do work for you? YES/NO. If yes, state name, trade and address of such other person.

Name: _____ Trade: _____

Address: _____

Pay and Hours of injured worker:

	Cash	Keep
31. (a) Gross Weekly Wages at time of Accident (excl. overtime)	\$ _____	\$ _____
(b) Average gross weekly earnings for past 12 months or for period of employment if less than 12 months (including overtime)	\$ _____	\$ _____
(c) Duration of working week (excluding overtime):		
(i) _____ hour (ii) _____ days		
(If employed by the hour)		(If employed by the days)
(d) Ordinary rates of pay for work :		
_____ per week		_____ per day

I/We will keep you advised of particulars concerning this workers progress or otherwise and will inform you when he returns to work or in my/our opinion is capable of doing so.

Employer's Signature: _____ Date _____ 19 _____

IMPORTANT : Please attach copy of Labour Department L.D. Form C/1.