



Eloham Risk Solution

The Workmen's Plan Claim Form

INSURED

Name	<input type="text"/>	Policy No	<input type="text"/>
Address	<input type="text"/>	Tel. No	<input type="text"/>
E-mail	<input type="text"/>	Fax No	<input type="text"/>

THE INJURED PERSON

Name	<input type="text"/>	Sex	<input type="text"/>
Address <i>(Residential)</i>	<input type="text"/>	Age	<input type="text"/>
Employment Status	<input type="text"/>		<input type="text"/>
	<i>(Whether Permanent, Contract or Casual Staff)</i>	Duration in your Employment	<input type="text"/> Years
Position/Rank	<input type="text"/>	Monthly/weekly Salary/wage	<input type="text"/>

*Attach 3 Month pay slip
Preceeding the incident*

DETAILS OF ACCIDENT

Date Of Occurrence	<input type="text"/>	Time of Occurred	<input type="text"/> AM/PM
Name of Injury	<input type="text"/>		
State similar injury sustained previously by the injured person	<input type="text"/>		

WITNESSES

Name	Address	Telephone No

DETAILS OF MEDICAL ATTENTION

Name & Address of Hospital or Clinic	<input type="text"/>
Name of Doctor attending to the injured person	<input type="text"/>
When will the injured person likely resume duty?	<input type="text"/>

OTHER INSURANCES

	Company	Policy No	Sum Assured

DECLARATION

I hereby declared that the foregoing statements/particulars are true and complete. I agree that my claim may be repudiated if any statements/particulars given above are found to be false.

Signature

Date