WORKERS COMPENSATION CLAIM FORM

CLIENT NO. _____

AGENCY NO. _____

WORKERS NAME.	POLICY NO.	DUE DATE	CLAIM NO.

ISSUE OF THIS FORM DOES NOT CONSTITUTE AN ADMISSION OF THE COMPANY'S LIABILITY

NAME:

ADDRESS:

PHONE: BUSINESS PRIVATE FACSIMILE

DATE OF INJURY OR DEATH:	TIME:

SECTION ONE - TO BE COMPLETED BY THE WORKER:	
NAME:	ADDRESS:
DATE OF BIRTH:	JOB DESCRIPTION:
DATE OF ACCIDENT:	PLACE OF ACCIDENT:
WHEN DID YOU STOP WORK: DATE: TIME:	WHEN DID YOU RESUME WORK: DATE:
WHAT ARE YOUR INJURIES?	
WHAT CAUSED YOUR INJURIES?	
ARE YOU MARRIED?	FULL NAME OF SPOUSE
DATE OF MARRIAGE	PLACE OF MARRIAGE
DOES YOUR SPOUSE LIVE WITH YOU. IF NO WHERE?	IS YOUR SPOUSE TOTALLY OR PARTIALLY DEPENDENT ON YOU(CIRCLE ONLY ONE)

PLEASE LIST ALL DEPENDENTS INCLUDING CHILDREN UNDER 16 YEARS OF AGE:

NAME	RELATIONSHIP TO YOU	DATE OF BIRTH	PLACE OF RESIDENCE	IS THE PERSON TOTALLY DEPENDANT UPON YOU. IF NOT, HOW MUCH?

SECTION 2 -TO BE COMPLETED BY EMPLOYER:

WAS THE INJURED WORKER DIRECTLY EMPLOYED BY YOU? YES/NO	IF NO, STATE DETAILS OF EMPLOYMENT:
AVERAGE WEEKLY EARNINGS (INCLUDING OVERTIME)	HOURS WORKED PER DAY:
HOURS WORKED PER WEEK:	RATE OF PAY PER HOUR:
HOW LONG HAS THE WORKER BEEN EMPLOYED BY YOU?	WAS THE WORKER ACTUALLY EMPLOYED AT THE TIME OF THE ACCIDENT?
WAS THE ACCIDENT REPORTED TO YOU OR THE WORKERS SUPERVISOR AT THE TIME OF OCCURRENCE?	IF NOT WHEN?

SECTION 2 -CONTINUED..

WHAT WAS THE WORKER DOING AT THE TIME OF THE ACCIDENT?	CAUSE OF ACCIDENT?
NATURE OF INJURIES?	DID THE WORKER CONTINUE WORKING AFTER THE ACCIDENT?
IF NO STATE TIME THE WORKER CEASED WORK:	DATE TIME:

IN YOUR OPINION WAS THE INJURY DUE TO NEGLIGENCE, DIRECT OR INDIRECT? IF SO STATE BY WHOM AND THE NATURE OF SUCH NEGLIGENCE:

WAS THE INJURY DUE TO THE SERIOUS AND WILFULL MISCONDUCT OF THE WORKER?

WAS THE WORKER SOBER AT THE TIME OF THE ACCIDENT?

ACCORDING TO YOUR RECORDS, WHAT DEPENDANTS DOES THE WORKERS HAVE.

NAME	RELATIONSHIP TO WORKER	DATE OF BIRTH	PLACE OF RESIDENCE	DEGREE OF DEPENDENCY

TO BE COMPLETED BY THE EMPLOYER

I/WE DECLARE THAT THE INFORMATION CONTAINED IN THIS CLAIM FORM IS TRUE AND CORRECT TO THE BEST OF OUR/MY KNOWLEDGE.

SIGNATURE OF EMPLOYER_____ DATE_____

TO BE COMPLETED BY THE INJURED WORKER

I HEREBY AUTHORISE ANY HOSPITAL, DOCTOR, OR OTHER PERSON WHO HAS GIVEN ME MEDICAL ATTENTION, OR MY EMPLOYER TO GIVE TOWER INSURANCE PNG LIMITED OR IT'S REPRESENTATIVES, ANY AND ALL INFORMATION WITH REGARD TO ANY INJURY OR SICKNESS, MEDICAL HISTORY, OR CONSULTATION I HAVE PREVIOUSLY HAD. I ALSO AUTHORISE THE COMPANY OR IT'S REPRESENTATIVES TO OBTAIN FULL HOSPITAL RECORDS AND EMPLOYER RECORDS AS REQUIRED.

I AGREE THAT A PHOTOSTAT COPY OF THIS AUTHORITY IS AS EFFECTIVE AND VALID AS THIS ORIGINAL.

AND I DECLARE THAT THE INFORMATION SUPPLIED IN THIS CLAIM FORM IS A TRUE AND ACCURATE STATEMENT IN REGARD TO MY CLAIM FOR COMPENSATION. I AGREE TO ADVISE MY EMPLOYER IF ANY CIRCUMSTANCES IN REGARD TO THIS CLAIM, MY DEPENDANTS OR MY MEDICAL CONDITION SHOULD CHANGE.

SIGNATURE OF WORKER _____DATE_____