Claim No.

Policy No.

INTRA AFRICA ASSURANCE COMPANY LIMITED

(INCORPORATED IN KENYA)

HEAD OFFICE
WILLIAMSON HOUSE
4TH NGONG AVENUE
TEL: 712610 712607/8/9
FAX: 254-2-712612
P.O. BOX 43241 NAIROBI, KENYA

BRANCH OFFICE
KENWOOD HOUSE, KIMATHI STREET
TELEPHONE: 334691/2
FAX: 332037
P.O. BOX 49884 NAIROBI

CLAIM FORM
WORKMEN'S COMPESATION

This form to be completed by the employer in duplicate as soon as practicable after the accident and sent to Agent of the area in which the accident or death occured.

(1) EMPLOYER

(a) Name.....

(b) Address.....

(c) Industry.....

(2) INJURED PERSON

(a) Name.....Father's Name.....

(b) Nationality.....Sex.....App. Age.....

(c) Job Description.....

(d) Address .....

District.....

.....

(3) ACCIDENT

(a) Date.....Time.....

Place.....

(b) Brief description of Cause.....

.....

.....

.....

(c) State exactly what the injured person was doing at the time

.....

.....

(d) If accident due to machinery, state

(i) Name of machine and part causing accident.....

(ii) Whether in motion by mechanical power at the time.....

.....

(4) INJURIES

(a) Give brief description of injuries as apparent to employer.....

.....

.....

(5) MEDICAL TREATMENT

(a) To what hospital or medical practioner was the injured person sent for treatment?

.....

.....

(6) EARNINGS OF INJURED PERSON

(a) Give rates at time of accident

(i) Rate of Wages	—	daily Shs	Monthly Shs.
(ii) Value of free rations	—	—	Shs.
(iii) Value of free housing	—	—	Shs.
(iv) Value of free fuel	—	—	Shs.

(v) Particulars and value of any bonuses or allowances other than above

EMPLOYEES

(a) Give the number of employees and rate of wages paid during the period of accident.

(1) No.....Occupation.....Wages.....

(2) No.....Occupation.....Wages.....

(3) No.....Occupation.....Wages.....

(4) No.....Occupation.....Wages.....

(5) No.....Occupation.....Wages.....

(6) No.....Occupation.....Wages.....

(b) Do you keep a proper wage book? .....

(c) Was the injured person in your direct employment? .....

(d) If so, since when was he empoyed?.....

(e) If the injured person was not employed directly by you, name the Sub contractor who employed him.....

.....

(f) Does the injured person come within the scope of compensation ordinance?.....

(g) Give particulars of any circular saws or other machinery driven by steam, gas, water or electricity or other mechanical power .....

(h) Were your machinery, plant and ways properly fenced and guarded, and otherwise in good condition?.....

.....

(i) Were all the conditions, stipulations, warranties of the policy fulfilled by you prior to the accident?.....

.....

(j) Have you completed Form LD 104/1. If no send a copy

I/We the undersigned, this .....day of .....19.....hereby declare that all the above statements and particulars, which I/We have read over and checked are true, that I/we have not suppressed or misrepresented or misstated any material fact, which would otherwise liable the claim to be rejected by the company. I/We further agree to give assistance in my/our power in dealing with this claim

Signed.....

Submission or issue of this claim form does not bind the company of any admission of liability