شركة أبوظبي الوطنية للتكافل ش.م.ع
تكافل
Takaful
Abu Dhabi National Takaful Co. P.S.C

Workmen's Compensation Accident Declaration Form

Policy No.________________________ Claim No. ________________________

1) Employer's Name & Address ____

2) Business ____

3) Name of Insured Person____

4) Age ___________ Single or Married ___________________ Occupation _____________________

5) When did he enter your Service ____

6) Date of Accident __________________________________ Time __________________________

7) Was he in your direct employment, or in that of sub-contractor ____________________________

If the latter, please state name and address of sub-contractor ________________________________

8) Place of Accident ____

9) a. Name of Police station of area where the accident took place ____________________________

b. When was the accident reported ____

10) What duty was he performing at the time of accident ___________________________________

11) Cause of accident (details) ____

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12) Nature and extent of injury ____

13) Probable duration of disablement ____

14) Name of witnesses and their addresses ____

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15) Was accident due to an another person's negligence _____________________________________

If so, please give particulars ____

16) If taken to hospital, state which and where ____

17) Have you any other insurance/ indemnity covering accidents ______________________________

to your employees? If so, give particulars ____

18) Date when the injured resumed duty ____

19) Other Remarks ____

DATE : **Employer's Signature & Stamp**