CERTIFICATE to be completed and signed by an eye witness and if possible by the person under whose direction the Workman was at the time of the Accident

**I hereby certify that I was present when the Accident occured to ____________________**

**____________________ on the ______________ day of ____________________**

**in manner above stated - that it was caused by ______________________________**

**______________________________ which was * / was not * his wilful act and**

**that he was* / was not * under the influence of drugs or alcohol at the time.**

Signed : Name ______________________________

Address ______________________________

______________________________

Occupation ______________________________

* strike out which is not applicable.

# OCCIDENTAL INSURANCE COMPANY LIMITED

Crescent Business Centre, 7th Floor, Parklands Road, Parklands,
P.O. Box 39459 Nairobi 00623, Kenya,
Tel: 020-2362602,020-8155965/6,020-8024149,
254-0722-202926,254-734-600485,
email: enquiries@occidental-ins.com
website:http://www.occidental-ins.com

## WORKMEN'S COMPENSATION INSURANCE CLAIM FORM

### IMPORTANT NOTICE

1. No liability under the policy is admitted by issue to this form.
2. Do not answer any third party communications about this Accident, but send them to us for action.
3. All Questions on this form must be answered.
4. Notwithstanding this form, you are required to comply with all the provisions of the Workmen's Compensation Act (Cap.236) relating to the procedure of reporting accidents, etc.

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Section 'A' Employer

Name ______________________________ Policy No: ____________

Address ______________________________

Period covering accident: From: ____________ To: ____________

Business or occupation ______________________________

______________________________ Telephone: ____________

Section 'B' Injured workman

1. Name and address : Mr/ Mrs / Miss ______________________________

2. a. Usual Occupation ______________________________

 b. Age ____________ Sex ____________

 c. Married or Single ______________________________

 d. Identity Card Number ______________________________ Attach Copy.

3. Was he / she in your direct employ or in that of a sub-contractor?

______________________________

4. If in your employ, how long has he been so employed? ____________

5. Give details of total earnings declared for insurance ____________

6. Give details of total monthly earnings at the of the accident.

| | | |
|---|---|---|
| Wages - | Shs ____________ | per month |
| Rations - | Shs ____________ | per month |
| Housing- | Shs ____________ | per month |
| other earnings/ allowance Shs. | Shs. ____________ | per month |
| TOTAL | Shs ____________ | per month |

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OCCIDENTAL INSURNCE COMPANY LIMITED

7. State precisely the nature of the work he / she was doing at the time of the accident ____________

8. How did the accident occur? ____________

9.a. When did the accident occur? State time, date and place

____________ am / pm on ____________ at ( place ) ____________

b. When did the injured employee cease work on account of accident?

State date:- ____________

10.a. Was he performing a duty for which he was employed?

b. Was he obeying any rule or order? ____________

c. Was the accident due to another person's negligence? ____________

If so, give particulars ____________

d. Was the accident due to any defect of machinery or plant?

e. Had such defect been brought to your notice? ____________

11. Did you take all reasonable precautions to prevent accidents of the nature occurring? If so, state fully the nature of the precautions taken. ____________

12. Was the injured person under the influence of drugs or alcohol at the time of the accident?

13.a. Under whose direction and control was the injured workman working at the time of the accident?

b. Did the accident occur whilst he was under such direction and control? ____________

14.a. Was the injured person suffering from any ill-health or bodily defect at the time of the accident

b. Were you aware of such ill-health or defect? ____________

15. State fully the nature of the injuries received ____________

16.a. Name and address of injured Workman's Medical Attendant

b. If in hospital or nursing home, give name and address

17. State how long was the injured workman off duty as a result of the accident? ____________

18. Does the workman still suffer any disability? If yes, state the nature of the disablement

19. State whether the injured workman is still in your employment ____________

I hereby certify that the above statement is full and true account to the best of my knowledge and belief .

DATE THIS ____________ DAY OF ____________ 20 ____________

EMPLOYER'S SIGNATURE
& CO. RUBBER STAMP

____________