REGENCYNEM INSURANCE LIMITED

No. 65 Patrice Lumumba Road, Airport Residential Area.
P. O. Box CT 6342 Cantonments, Accra, Tel: 233-302-778106/769789/768463 Fax: 233-302-782871

WORKMEN'S COMPENSATION CLAIM FORM

INSURED ..... TRADE OR BUSINESS

POLICY NO.: ..... ADDRES S.....

1. (a) Full Name: .....

(b) Address: .....

(c) Occupation and Age:.....

(d) Marital Status:.....

(f) How long has he continuously been in your employment?

2. Date of Accident:..... Time: .....Place:

3. (a) Date on which injured worker ceased work consequent upon the accident...

(b) Date of resumption of work:.....

4. Please give a full description of how the accident happened .....

5. (a) Please state the exact nature of injuries sustained by the worker

(b) Was the accident caused by the negligence of the injured worker or his/her co-worker?

YES/NO, If yes please explain .....

Names and addresses of witness:

(c) Where was injured workman taken to Hospital/Clinic .....

(d) Give name of Hospital / Clinic injured worker was taken to.....

Provide Address and Telephone No. of Hospital / Clinic .....

I / We declare that the above statement is true in all respects to the best of knowledge and belief and we undertake to go information and assistance as the company may require.

Date: Signature of Policyholder