BHARTI AXA GENERAL INSURANCE COMPANY LIMITED, RMZ Infinity, B - Tower, 2nd Floor, No. 3, Old Madras Road, Bangalore - 560016. Tel: 080-40260200.

RMZ Infinity, B - Tower, 2nd Floor, No. 3, Old Bangalore - 560016. Tel: 080-40260200. Toll-Free Helpline: 1800-103-2292 E-mall: claims@bharti-axagi.co.in www.bharti-axagi.co.in



WORKMEN'S COMPENSATION/EMPLOYERS LIABILITY CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSIBILITY OF LIABILITY.	LWC
Please fill this form in Block Letters and Tick the Boxes where appropriate and do if any detail or information is not readily available, please do not delay despatch of this resent later.	
Policy Number:	
Claim Number:	
Period of Insurance: DIDIMIMIYIYIYIY to DIDIMIMIYIYIYIY	
A. DETAILS OF INSURED	
Name:	
Address:	
	Pin code:
Telephone No.:	
E-mail Address:	
If Insured is not the sole owner, for the nature of his / their interest in the property and the details of other Inte	
B. DETAILS OF PRINCIPAL / SUBCONTRACTO	ORS
Name:	
Address:	
	Pin code:
Telephone No.:	
E-mail Address:	S. D. A.
C. DETAILS OF INJURED/DECEASED PERSO	ON
Name:	
Father's/Husband's Name:	
Age/Date of Birth: Sex:	Male Female
Local Address	
	Pin code:
Native Address	
	Pin code:
Occupation in which Injured/deceased person was employed:	
On what work was the Injured/deceased person engaged at the time of accident:	
Was the injured/deceased person actually working at the time of accident:	

Name and Designation

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-	THE PARTY OF THE P
Forming Part of	of Claim Number:

WORKMEN'S COMPENSATION/EMPLOYERS LIABILITY CLAIM FORM

	STATEMENT OF INJU	RED/DECEASED PERSON'S EARNI	NG
tatement of wag	es fallen due to payment to	in the emplo	
eriod as he may h	for 12 mont ave been in the employer service.	hs prior to the date of his accident or wages e	arned during such short
		e extra average monthly earning of the injured	nerson It is essential that
nould carefully ar ervice is essential fresumption of d	nd correctly filled in, if the injured p so also if he was absent continuous	erson has been in service less than twelve mor ly for more than 14 days (within 12 months) be	iths his dated of entry in
ate on which the	e injured person resumed duty afte	er a continuous absence of more than 14 days	
Month and year	Wages earned (Including overtime)	Value of bonus, food subsidy, if any free quarter and any other allowance etc.	Absences
	Rs.	Rs.	
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
Total earning in the period			
otal including all	allowance Ps		
otal including all		PECIAL NOTICE	
verage monthly v Please state the e	od of service was less than one mo wages a workman employed on si exact nature of the allowance and aces give date of going on leave or	onth give the) Rs. milar work	date of subsequent
he above statem	ent of earning etc. is to the best of	my knowledge and belief accurate.	
)ate:			Signature of Employer



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