اینسورنس ستندارد سندیرین برحد

Standard Insurance Sdn Bhd
(Incorporated in Negara Brunei Darussalam)

Unit No. A11, Block A, Bgn. Habza, Spg. 150, Kg. Kiarong, BE1318, Negara Brunei Darussalam
Telephone Nos.: 224 0401 • 224 0402 • 224 0403 • 224 0404 Fax No.: 224 0405

Requirement	
1	Claim form to be completed
2	Copy of BUR500/555
3	Copy of Employment Contract
4	Copy I/c or Passport
5	Copy Salary past 6 mths
6	Original Medical bills
7	Original Medical Sick Certificate
8	Medical report, if any
9	Form A, If report to Labour Dept.

Workmen's Compensation Claim Form

IMPORTANT NOTICE

1. Full particulars of the accident are to be furnished by the Employer.
2. The giving of the undermentioned information does not imply that the injured person is making, or will make, a claim.
3. This form is sent without prejudice to the terms of the policy.
4. If any details or information are not readily available, please forward this form without delay, and supply the missing d
5. All written communications received by the Employer concerning the accident to the employee should be forwarded a

1. Claim No.	2. Client No.	3. Policy No.	4. Account No.

5. INSURED

Name of Policyholder	
Business	
Address and Telephone No.	
Policy No. and Expiry Date	

6. INJURED WORKMAN

Name		Age		Sex	
Nationality		Tel. No.			
Local Address					

State occupation in which the injured person is employed.	
Was the injured person engaged in this occupation when the accident occurred?	
Is the injured person in your direct employ? If not, give name and address of Contractor	
When did The injured person enter your service?	
How many workers are employed by you at the time of this accident.	
Name of hospital taken to.	
In or out-patient.	
State whether stiil in hospital, or when discharged.	
Has the injured person been medically examined? If so, please send report. If not, was free medical examination offered?	
State whether returned to work, and if so, when.	
Are you satisfied the injured person has met with a bona fide accident arising out of his employment?	
Is the injured person able to do partial work?	
What is the probable period of disablement (approximate)?	

7. ACCIDENT PARTICULARS

Date		Time		Place	

On what date did you receive notice of accident and from whom? if in writing, please attach to this form.	
On what date did the injured person actually cease work?	
If accident was due to machinery or gearing please state: (a) Whether it was fenced or guarded. (b) Was it being cleaned whilst in motion.	
What was the general nature of the contract or work going on?	
State nature of injury.	
State regions injured.	
State right or left side.	
Was the injured person under the influence of drink or drugs at the time of the accident?	
Was be guilty of any misconduct or disobedience to orders or rules? If so, please give full particulars.	
State through whose neglect the accident occurred. If any.	
If the injury was caused by any person or persons not in your employ please advise full names and addresses of those concerned.	
State the names of any persons who witnessed the accident.	
Has the accident been reported to the Commissioner or Police or Commissioner for Labour? State when and where.	

8. WAGE

State of wages of the injured person earned **IN THE PRESENT EMPLOYMENT** for the six months immediately prior to the date of this Accident, or wages earned during such shorter period as he may have been in the Employer's service, statinq the date on which he was engaged.

Note: The object of this form is to ascertain the **exact Monthly earnings** of the injured person. It is essential that it should be carefully and correctly filled in. If the injured person has been absent from work at any time during the period of his employment, please state the period and cause.

YEAR	MONTH	MONTH		Bonus Value of Free Quarters, and any other Allowance	
		$	cts.	$	cts.
	TOTAL				
		Total including all Allowances			

I/We certify that the foregoing is true and correct to the best of my belief.

Date: _____ 20 _____ Signature of Employer _____