اينسورنس ستندارد سندرين برحد
Standard Insurance Sdn Bhd
(Company Registration No. RC00000537)
Address : Unit No. A11, Block A, Bgn. Habza, Spg. 150, Kg. Kiarong, BE1318, Negara Brunei Darussalam
Postal Address : Berakas MPC P.O. Box 12, BSB, BE3577
Tel: 2240401 • 2240402 • 2240403 • 2240404 Fax: 2240405

Requirement:-

1. Completed claim form.
2. Copy of LD form.
3. Copy of Employment Contract.
4. Copy of I/C or Passport.
5. Copy of past 6 month's salary.
6. Original copy medical bills.
7. Original copy of Medical Sick Certificate.
8. Medical report, if any.
9. Form A (if reported to Labour Dept.).
10. Picture of injury.

Claim Form - Workmen's Compensation

IMPORTANT NOTICE

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

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

5. INSURED

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

6. PROJECT INFORMATION

Project Title		Project Number	
Project Location			

7. ILL / INJURED WORKMAN

Name		Age		Sex	
Nationality		Telephone No.			
Local Address		Hometown Address			
Occupation					
Was the ill/injured workman engaged in this occupation when the accident occurred?					
Was the ill/injured workman in your direct employ during the accident? If not, give name and address of Contractor which the injured workman was in service to.					
When did the ill/injured workman enter your service?					
Which medical institution was the ill/injured workman taken to?					
Inpatient ☐ Outpatient ☐					
Is the ill/injured workman still hospitalised? If not, when was he/she discharged?					
Has the ill/injured workman returned to work, and if so, when?					
Are you satisfied the ill/injured person has met with a genuine accident arising out of his/her employment?	Yes ☐	No ☐			
Is the ill/injured workman able to partially resume work?	Yes ☐	No ☐			
What is the probable period of disablement? (approximate)					

8. ILLNESS / ACCIDENT PARTICULARS

Date		Time		Place	
On which date did you receive notice of the illness/accident and from whom?					
On which date did the ill/injured workman 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?	(a) (b)				
State nature of illness/injury.					
State region(s) injured.					
Was the injured workman under the influence of alcohol or drugs at the time of the accident?	Yes ☐	No ☐			

Has the injured workman been guilty of any misconduct or disobedience to orders or rules? If so, please give full particulars.	
State through whose negligence that caused the accident to occur, 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 name or any person(s) who witnessed the accident.	
Has the accident been reported to the High Commissioner or Embassy or Police or Department of Labour? State when and where.	

Are you presently insured for accident benefits with other Takaful Operators / Insurance Companies? If yes, please state the following:

Name of Takaful Operators / Insurance Companies			
Policy Number		Amount of Benefits	
Insurance Effective Date			

9. STATEMENT OF INCIDENT

10. WAGE

State wages that the injured workman 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, stating the date on which he was engaged.

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

Year	Month	Wages		Bonus Value of Free Quarters, and any other Allowance	
		$	¢		
	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 _____

(Sign & Company Stamp)