WCC-1

WORKERS COMPENSATION FUND
COMPENSATION CLAIM FORM

(Regulation 19(1))

(This Form may be filled by an employee, employer or any person on behalf of an employee)

A. NATURE OF CLAIM (Mark (√) appropriately)

Occupational accident		Occupational disease		Death	

B. EMPLOYEE'S PARTICULARS

Name of employee ……..……..……
Employee's code No. ……National ID ……...Employee's ID ……
Job title …… Section/Department……Monthly earning…….
Date of birth……Sex…… Marital status……..……No. of children……..….
District……..……. Region ……Nationality……..…
Street/Village ……..Plot No…… Block No…….……...……
Tel……...Fax…….…….. Cell phone…….……...…….
E-mail…….. Next of kin……..……..……..

C. PARTICULAR OF THE DECEASED'S REPRESENTATIVE (IN CASE OF DEATH)

Name ……Contact address.....
National ID ……...Relationship with the deceased ……
Date of birth……Sex…… Marital status……..……No. of children……..….
District……..……. Region ……..……..Nationality……..…
Street/Village ……..Plot No…… Block No……..……...…
Tel……...Fax…….…….. Cell phone……...…….
E-mail…… ……..……..……
Date and time of death of the deceased employee …… (**Attach certified copy of death certificate)**
Place of death ……..
Cause of death **(Mark (√) appropriately)** occupational accident ( ) or occupational disease ( )

Name of medical practitioner who attended the deceased employee……...…..……

D. EMPLOYER'S PARTICULARS

Name of employer……...……....
WCF Reg. No ……..……
Contact address…….....Street/Village…….....
District……..…….Region……Country……
Tel ……..Fax……Cell phone……..……..
E-mail……

E. PARTICULARS OF OCCUPATIONAL ACCIDENT OR DISEASE

i. Date of notification of an occupational accident or disease to the employer…….
ii. Injuries sustained as a result of an occupational accident or disease…….....
……
……
……

iii. How did you know that you have an occupational disease? (Mark (√) appropriately)

Statutory medical examination		Follow up for the illness		Others	

If others, explain …….
……..

F. EMPLOYMENT HISTORY (to be completed in case of occupational disease)

i. Current employer

S/No.	Job title (Start with current title)	Section/Department	Activity performed	Duration	
				From	To
1.					
2.					
3.					
4.					
5.					

(Attach relevant documents)

ii. Previous employer (s) if any

S/No.	Job title	Employer	Section	Activity performed	Duration	
					From	To
1.						
2.						
3.						
4.						
5.						

(Attach relevant documents)

G. PAYMENT OF MEDICAL EXPENSES (Mark (√) appropriately)

Employer	Employee	Insurance	Others

If medical expenses were paid by an Insurance

i. Name of the insurer …….
ii. Go to section **J**.

H. INITIAL MEDICAL CARE PARTICULARS

i. First date of treatment after occurrence of an occupational accident or disease……..……
ii. For occupational accident, provide the name of first health care provider where the employee was attended ……...
iii. Name of the health care provider where an occupational disease was established ……..……
……

iv. Health services received at the first health care provider

Health service	Hospitalization		Treated as out Patient		Medical investigation		Specialized clinic consultation		Surgery		Referral	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Mark (√) appropriately												
Cost incurred												

Total cost incurred ……
Name, address and contact of the medical practitioner: ……...
……
……

I. REFERRAL PARTICULARS

i. First referral health care provider……

Health service	Hospitalization		Treated as out Patient		Medical investigation		Specialized clinic consultation		Surgery		Referral	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Mark (√) appropriately												
Cost incurred												

Total cost incurred ……

Name, address and contact of the medical practitioner:
……
……
……

ii. Second referral health care provider ……...

Health service	Hospitalization		Treated as out Patient		Medical investigation		Specialized clinic consultation		Surgery		Referral	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Mark (√) appropriately												
Cost incurred												

Total cost incurred ……

Name, address and contact of the medical practitioner
……
……

For any further referral please explain……..
……
……

J. CURRENT STATE OF EMPLOYEE

1.	**Health state**	Completely recovered	Attending hospital/ specialized clinic	Permanent loss of body part or function (s).	Resumed work
	Mark (√) appropriately				
2.	**Disability**	Hospitalization	Day off (ED)	Light Duties	Bed ridden
	No. of days				

For ongoing medical follow up

1. Name and address of the health care provider
   ……
   ……
2. Name, address and contact of the medical practitioner
   ……
   ……

K. Have you ever been paid any compensation in relation to the same occupational injury? Yes/No

i. If yes, which type of compensation were you paid …….
ii. Who paid such compensation (e.g. WCF)……
iii. When was compensation paid ……..

(Attach relevant documents)

EMPLOYEE'S DECLARATION
(May be filled by any person on behalf of an employee)

I, ……., declare that what I have stated herein above is true to the best of my knowledge.
Name……..
Signature…….
Date……

EMPLOYER'S VERIFICATION
I, ……., verify that what is stated from item A to item K is true to the best of my knowledge.

Name……..
Signature…….
Date……

NOTE: Employer must submit an occupational accident or disease investigation report.

For Workers Compensation Fund use only

Received by

Name of the officer	**Designation**	**Date**	**Signature**