



**WORKERS COMPENSATION FUND
DEPENDANT COMPENSATION CLAIMS FORM**

WCP-7

(This form shall be filled by dependent or any other person on behalf of the dependent)

A. PICTURE OF DEPENDENTS (Colored picture should be attached in box)

Dependant 1	Dependant 2	Dependant 3	Dependant 4
Dependant 5	Dependant 6	Dependant 7	Dependant 8

B. PARTICULARS OF THE DECEASED

First Name..... Middle Name Last Name

Name of the Employer of the deceased employee; WCF Reg. No.

Date of death..... Death certificate Number.....

C. CLAIMANT PARTICULARS

Name of the claimant.....

Relationship with the deceased

National ID Contact address.....

Date of birth..... Sex..... Nationality.....

Ward District..... Region

Street/VillagePlot No..... Block No.....

Tel.....Fax..... Cell phone.....

E-mail.....

D. DEPENDANTS PARTICULARS

Names of the spouse (s) of the deceased and children of the deceased who are under the age of 18 years or above if suffering with mental conditions. In case there is no spouse(s) or children of the deceased, names of other financial dependents of the deceased.

S/n	Photos	Name of Dependent	Date of Birth	Relationship with the deceased
1.	Photo No. 1			
2.	Photo No. 2			
3.	Photo No. 3			
4.	Photo No. 4			
5.	Photo No. 5			
6.	Photo No. 6			
7.	Photo No. 7			
8.	Photo No. 8			

E. DEPENDANTS PAYMENTS DETAILS

S/n	Photos	Name of Dependent	Bank Name	Account No	Branch
1.	Photo No. 1				
2.	Photo No. 2				
3.	Photo No. 3				
4.	Photo No. 4				
5.	Photo No. 5				
6.	Photo No. 6				
7.	Photo No. 7				
8.	Photo No. 8				

F. CLAIMANT'S DECLARATION

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

Name.....Signature.....Date.....

G. ATTESTING WITNESS

(Attesting witness includes Judge, Magistrate, District Commissioner or Regional Commissioner.)

Name of the attesting witness.....

Designation of the attesting witness..... Date

Signature and rubber stamp of the attesting witness