

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 ($\sqrt{}$) appropriately)

	Occupational accident		Occupational disease		Death		
3.	EMPLOYEE'S PARTICULAR	RS					
			_	_			
	First Name						
	Employee's code No						
	Job title						
	Date of birthSe						
	District						
	Street/Village	Plot No		Block No			
	Tel	Fax		Cell phone.			
	E-mail		Next of kin				
J.	PARTICULAR OF THE DEC	EASED'S	REPRESENTATIVE	(IN CASE	OF DEAT	ГН)	
	First Name	Middle	Name	La	st Name		
	Contact address						 .
	National ID						
	Date of birthSe						
	District						
	Street/Village						
	Tel	Fax		Cell phone			
	E-mail						
	Date and time of death of the dec						
	copy of death certificate)	cuseu emp	10 y 00		(22000	cm ccr cm	icu
	Place of death						
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	Cause of death (Mark ($$) appro	priately) (•				
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Health service	Hospitalization		Treated as out Patient		Medical investigation		Specialized clinic consultation		Surgery		Refe	
service	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	
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current	s and co	al please	he medio	ZEE	Attend specia	ing hospital/	Pern	nanent loss of b	ody R			

J.

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

l,		declare	that what I have stated herein above
is true to the best of my kno		,	
Signature			
Date			
	FMPI OVI	ER'S VERIFICATION	
T	_		varify that what is stated from
item A to item K is true to the			, verify that what is stated from
Name			
Signature			
NOTE: Employer must su	bmit an occupational	l accident or disease inv	estigation report.
F. Received by	For Workers Compen	sation Fund use only	
Name of the officer	Designation	Date	Signature