Claimant's photo

WORKERS COMPENSATION FUND **WCP-7**
DEPENDANT COMPENSATION CLAIMS FORM

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

A. 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…….

B. CLAIMANT PARTICULARS

Name of the claimant…….....
Relationship with the deceased ……..……
National ID …… Contact address.....
Date of birth…… Sex……. Nationality…….……..…….....
Ward ……District……...…… Region ……..……
Street/Village ……..Plot No……..… Block No……..…….
Tel……...Fax…….…….. Cell phone……..
E-mail……..……..……..

C. 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.

SR/N	First Name	Middle Name	Last Name	Relationship with the deceased	Date of Birth	Place of Birth	Address
1.							
2.							
3.							
4.							
5.							
6.							
7.							

D. DEPENDANTS PAYMENTS DETAILS

SR/N	First Name	Middle Name	Last Name	Bank name	Account No.	Branch
1.						
2.						
3.						
4.						
5.						
6.						
7.						

E. CLAIMANT'S DECLARATION

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

Name……..Signature……Date…….

F. 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 …….