ســيْب
Seib
تـأميــن وإعـادة تـأميــن
INSURANCE & REINSURANCE
PO Box: 10973
Doha - Qatar

Seib Insurance & Reinsurance Company LLC

WORKSMEN'S COMPENSATION (EMPLOYER'S LIABILITY) CLAIM FORM

(Issuing this claim form does not constitute an admission of liability on the part of the company)

1	Name of the insured in full	
2	Address of the insured	
3	Details of the business activity of the firm and number of years of operation:	
4	Policy details Number: Period: Type:	 -- -- --
5	**Details of ill/injured/deceased employee:**	
	a) Number of Injured/deceased employee	
	b) Post held	
	c) Nationality	
	d) Gender	
	e) Marital Status	
	f) Age	
	g) Wage/Salary per day	
	h) Salary per month	
	i) Duty Working Hours	
	j) Duty Working Days	
	Attach evidence thereof	
6	**Details of incident:**	
	a) Day, Date, & Time	
	b) Place of incident	
	c) How accident happen? Give brief particulars	
	d) Nature of Injury	
	e) Cause of Injury/death	
	f) Is this road accident?	
	g) Is third party liable for the accident? Give name & address (kindly attach police report)	
	h) Was he on duty at the time of the accident? ***Attach evidence thereof***	

7	**In Case of Death Compensation:** Name of the Beneficiary & full address:	
8	Any witness to the incident? If so, please attach witness statement. **Name(s) of Legal Heirs with their address:**	
9	Any Recovery achieved? (Through police/direct). If any, please give Name & address of the claimant, who bears power of attorney to receive death compensation: **(Please Attach death certificate, all medical reports & other relevant documents in support of above information)**	
10	**In case of illness/ injury:**	
	a) When was he admitted into the hospital?	
	b) When was he discharged from the hospital?	
	c)Total no. of days absent from duty on medical advice.	
	(Attach all medical reports & other relevant documents in support of above information)	
11	Name(s) & address of Doctor(s) who attended to the ill/injured/deceased person.	
12	Attach incident report on the sequence of happenings signed by authorized signatory.	
13	Any recovery achieved? (Through police / direct). If any, please give details thereof.	
14	Improvements in the working system proposed/effected to avoid such recurrence.	

Declaration:

I/We do further declare to the best of my/our knowledge & belief that the foregoing particulars are true & correct.

Signature of the Insured/Claimant: ____________________ Date: ____________________

Name: ____________________ Stamp: