WORKERS' COMPENSATION CLAIM FORM

Contents

A. NOTES

1. Please read this Claim Form fully before answering the questions.

2. No admission of liability or agreement or payment of any amounts to any person/Company/Entity/Corporation without the consent of the Company is a breach of acondition of this policy and will void any possible claim

3. The claim form is to be completed and signed by a partner, director or principal of the insured.

4. All questions must be answered as fully as possible. Please use additional sheets ifnecessary and copies of relevant documentation should be attached.

5. If you have any questions in relation to completion of the claim form, please contact your insurance advisor or broker.

6. Please send the completed claim form, as soon as possible, to your insurance advisor or broker.

7. Appointment of legal representatives should not occur without the prior consent of TransPacific Assurance Limited

NOTE: No liability of any sort shall be admitted nor any offer, promise or payment madeby the assured to claimants nor legal expenses incurred without the written consent of thecompany who shall be entitled if it so desires to take over and conduct on the name of theassured the defence of any action, or to prosecute any claim or indemnity or damages or otherwise against any third party.

The assured also undertakes to send to the company as soon as possible, all claims letters,summonses or writs relating to any accident address to the assured or to the assureds or servants by the authorities or parties

B. EMPLOYER DETAILS

1. Name of employer.....

2. Business or Profession .....

2. Address .....

..... Postcode .....

3. Business Tel No ..... Mobile Tel No.....

   Fax No.....

4. Email .....

C. ACCIDENT DETAILS

1. Day of week ..... Date ..... Time .....am/pm

2. State exact place of locality where injury was sustained .....

.....

3. Did the injured person give notice of injury? Yes No

4. To whom it was given? .....

NOTE: If the worker failed to give notice of the injury as soon as practicable after its happening, he/she is required to supply a written signed statement containing his/her explanation, and showing reasonable cause why notice of injury was not so given.

1. When it was given? ..... am/pm Date ...../...../.....

2. Verbally or in writing .....

3. Give the names of person or persons who were actual eye witnesses of the injury.

.....

.....

.....

4. Describe fully the circumstances leading to the incident .....

.....

.....

.....

.....

5. What is the nature of injury? .....

6. If the injury was caused by any person or persons not in your employ, please advise full name and address of those concerned

.....

.....

D. INJURED EMPLOYEE DETAILS

1. Name of injured person: .....

2. Address: .....

..... Occupation: .....

3. Industry in which employed: .....

   (E.g. Farming, Coal Mining, Clothing Manufacture, Road Construction, Flour Milling)

4. How long in your employment: .....

5. State the operation at which the worker was engaged at the time of accident:

.....

7. Was injury sustained in the course of worker's employment with you? .....

8. Did the injury arise out of worker's employment with you? .....

9. Was the worker in the service of any other employer at the time?.....

10. Was the worker injured while doing something which he/she was not part of his/her particular employment to do, or was he/she injured at a place or part of the works where he/she was not required to be by his/her particular employment?

.....

.....

11. Schedule:

Age	Marital Status	No of days worked per week	Total earnings in your employ for previous 12 months (or part thereof) *	Average weekly earnings	Is board and lodging provided in addition to weekly wages	Date and time discontinued working	Length of time worked on day when injury occurred
						Date .... am/pm	

12. Is the injured person related to you? .....

If so, what is the relationship and does he or she resides with you?

.....

13. State clearly if injured person is casual, permanent or working under contract:

.....

E. COMPENSATION DETAILS

1. Has the injured person returned to work? Yes No

If yes, Date .....

2. Is compensation being claimed or received from any other source? .....

.....

.....

3. Was the injured person free from physical infirmity at the time of the accident?

.....

4. Are you aware whether the worker has ever previously suffered from a similar injury?

.....

.....

5. Was the part affected by this accident quite normal before the incident? Yes No

If "No", please give full details .....

.....

6. Would such physical defect or infirmity have contributed towards this accident?

.....

7. If the worker has received any medical, surgical or hospital treatment please state under which hospital and forward medical certificate if available.

   a) Name of Hospital: .....

   b) Whether in-patient or out-patient: .....

   c) Name and address of doctor: .....

8. Supplementary remarks as to anything affecting the cause or probable consequences of the injury. (If it is considered practicable to give an opinion, please state the approximate period of incapacity which it is expected will result from the injury).

.....

.....

.....

9. Details of dependents (to be completed after consultation with employee)

Names	Date of Birth	Relationship	State whether wholly or partially dependent

F. NOTES

1. The company will require an explanatory report in the event of:
   a) The injury being caused by any defect in works, ways, machinery, or plant;
   b) The violation of any statutory or other regulations by the “worker” at the time of the injury;
   c) Any serious and willful misconduct on the part of the “worker” contributing tothe injury;
   d) The injury having being caused by the negligence of any person other than the employer.
2. Witnesses’ statements, if procurable, should be obtained and forwarded, especially:
   a) If doubt exists as to the circumstances under which a reported injury occurred;
   b) In the event of hernia, sprains, strains, shock, jars and case where the injury occurred;
   c) Where the injuries sustained are obviously serious.

Any change in the address of an injured worker is to be immediately notified to the Company

G. SCHEDULE FOR MEDICAL, HOSPITAL AND ASSOCIATES EXPENSES

NAME OF INSURED PERSON	NAME OF HOSPITAL,CLINIC,DOCTOR,DENTIST	HAVE ACCOUNTS BEEN PAID YES/NO	TYPE OF INJURY SICKNESS OR TREATMENT	DATE OF TREATMENTOR PERIOD OF CONFINEMENT	AMOUNT INCURRED
Less expenses not covered (office use only) Less amount of deducible Reimbursement					

H. DECLARATION

I/We declare that:

The information and answers given above are correct to the best of my/our knowledgeand belief.

I/We understood the claim may be refused or reduced if information is withheld.

I/We authorise Trans Pacific Assurance Limited to disclose information contained herein to Trans Pacific Assurance Limited advisors, reinsurers, and other insurers. I/We authorise Trans Pacific Assurance Limited to obtain from any other party information that is, in Trans Pacific Assurance Limited s' view relevant to this claim

Signature of Insured .....

Date ...../...../.....

Level 3, Credit House
Cuthbertson Street
Port Moresby
National Capital District
121

+675 321 6808

info@transpacific.com.pg

www.transpacific.com.pg

THE INTELLIGENT INSURER