CLAIM NO.....

SIC INSURANCE COMPANY LIMITED

P.O. Box 2363, Accra Ghana
HEAD OFFICE: NYEMITEI HOUSE 28/29 Ring Road East. Tel (030) 2-280600-9 Fax (030) 2-780615
Ring Road West: (030) 2-228926/ 228922/228962/228987/ 230041-2, Fax (030) 228970/ 224218
E-mail:sicinfo@sic-gh.com Website: www.sic-gh.com

WORKMEN'S COMPENSATION CLAIM FORM

I/We give you hereunder particulars of an accident to one of our workmen, and shall be glad to furnish any further information you may require

Employer's Signature.....

Trade or Business.....

Date..... Address.....

DETAILS OF INJURED WORKMAN	
1. (a) Full Name	(a).....
(b) Address	(b).....
(c) Occupation and Age	(c) Occupation.....Age.....
(d) State if married & number of children	(d).....
(e) Amount of weekly earnings	(e).....
(f) He/she is in direct employ of	(f).....
(g) How long has he/she worked for you?	(g).....

2. The accident happened at am/pm on the day of

at (place).....

3. The injured workman ceased work on the day of

4. The accident happened thus :- (N.B. Please give fullest description, stating particularly if caused by machinery, or by the fault, of any person. In the latter case give name of person and state by whom employed).

5. The workman sustained the following injury or has contracted the following disease:

6. The workman and address of witnesses are:-	(1).....
	(2).....
	(3).....
	(4).....

IMPORTANT: IN THE EVENT OF THE ACCIDENT RESULTING IN DEATH, IMMEDIATE NOTICE MUST BE GIVEN TO THE COMPANY BY FAX OR TELEPHONE