Stated Benefit
Claim Form

Policy number	Insurer

1 Insured (workman)

Name and occupation			
Physical address			
Identity/Passport number		Marital status	
Age		Sex	
Contact details	Business	Email	Cell

2 Employer

Name or style of employer

Business or occupation

Address

Date of last premium	D D M M Y E A R	Nature or trade of business

Was he/she your direct employ, or in that of a sub-contractor

If in your employment, how long has he/she been so

Total earnings for 12 months immediately preceding the accident

State f**ully** the work he/she was doing at the time of the accident

3 Injury/Illness

When and where did accident occur or illness commence

Date .... Time .... Place ....

Give full particulars of the accident and nature of injuries or the name of the illness

State to what extend the injured person is disabled and whether absolutely prevented from following his employment

At what hour .... and on what date .... was the injury first attended to by a Medical Practitioner.

Have you received notification of Magistrate or other enquiry, and if so, State when:

Where same will be held:

Was the injury/illness caused by

Violation of rules?		Carelessness of any other person?		Carelessness of any other workman?		If so, who?
Yes	No	Yes	No	Yes	No	

Injury/Illness continued

Any defect in the condition of the premises, work, plant or machinery? If so, had such defect been brought to your notice

....

Was the injured person perfectly sober at the time of injury ....

Under whose direction was he/she at the injury time ....

Was it caused by carrying out such directions ....

Was the injured person suffering at the time of the accident from ill-health or bodily defect of any description ....

....

Has the injured person previously received compensation for an accident sustained either whilst in your service or in that of a previous employer? If so state, the date of the accident ....

the amount of the compensation received ....

Cash wages/salary (exclusive of overtime, bonus, payments etc.) Maloti	**M**
Value of rations	**M**
Value of housing	**M**
Value of fuel	**M**
Overtime payment or other special remuneration for work done, whether by way of bonus or otherwise, if of constant character, and for work habitually performed	**M**
Total earnings per month	**M**

4 1st Witness

Name ....

Address .... Tel ....

2nd Witness

Name ....

Address .... Tel ....

5 Disablement

Period of temporary total disablement From .... To ....

Period of temporary partial disablement From .... To ....

Give date of normal occupation resumed ....

Has any permanent disablement resulted? Give details ....

....

6 Doctor/Hospital

Name and address of doctor/hospital who attended you ....

....

Name and address of your usual doctor/hospital ....

....

7 Other Insurance

Give names of any other insurer with whom insured person is insured ....

....

8 Payment method - (Employer) (NB. Bank letter required)

Please specify the name of the bank, branch, name of account and account number.

Name of Bank		Branch	
Name of Account		Account Number	

9 Declaration

I/We hereby declare the foregoing particulars to be true in every respect

Signature of employer	Capacity
	Date D D M M Y Y Y Y

10 Medical Information PART II

(FOR USE BY MEDICAL PRACTITIONER ATTENDING OR EXAMINING THE INJURED/ILL WORKMAN

Date admitted to hospital:	In-patient No:
Date discharged	

Attendance as out patient	From	To

Nature of injury ....

(X) Permanent incapacity .... per cent

(X) Temporary incapacity-Likely duration of absence from work (from date of accident) .... Days/Months

Is a further examination required before final assessment of permanent incapacity can be given ....

Name .... Medical Practitioner Signature ....

Date .... Tel ....

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