الشركة الكويتية القطرية للتأمين
Kuwait Qatar Insurance Company

WORKMENS COMPENSATION CLAIM ADVICE

Policy No.	Claim No.

THE ISSUING OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY BY THE INSURER.

THE INSURED: _____

THE INJURED

1. Name: _____ 2. Occupation: _____
3. Nationality : _____ 4. Age: _____ 5. Male /female: _____
6. No. of working days per week: _____ 7. Monthly salary/daily wages:_____

THE ACCIDENT

8. Place: _____ 9. Date : _____ 10. Time:_____
11. Circumstances and description of the accident: _____

_____

_____

_____

12. Nature and extent of injury: _____

_____

_____

13. Whether the police were informed of the accident. ☐ Yes ☐ No
(if so, please enclose Police Report.)

14. Name (s) and address (es) of other person (s), if any, involved in the accident):

_____

_____

15. Name (s) and address (es) of witness (es): _____

_____

_____

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MEDICAL TREATMENT (Please enclose original medical certificate (s) stating details of the injuries, treatment and duration of sick leave, if any, recommended.)

16. Name and address of the doctor by whom treatment was given: _____

_____

17. Has the injured employee resumed his duty? _____ 18. when? _____

19. Following documents are attached hereto :-
(Please tick (√) the appropriate box.)

- ☐ Original certificate of sick leave from Ministry of Health
- ☐ Original preliminary medical report issued by Ministry of Interior
- ☐ Original medical board's report on permanent disability from Ministry of Health
- ☐ Directive from the Sharia Court
- ☐ Directive from the Department of Labour
- ☐ Death Certificate
- ☐ Police report (if the matter is reported to police)
- ☐ Copy of Civil ID card
- ☐ _____

Date:

_____
Signature of the Insured

FOR OFFICE USE ONLY

Computation of compensation payable:-