LONPAC INSURANCE BHD

(Incorporated in Malaysia)
101 Thomson Road #18-01 United Square Singapore 307591
Tel: (65) 6250 7388 Fax: (65) 6253 2058

WORKMEN'S COMPENSATION INSURANCE
NOTICE OF ACCIDENT

N.B.
1. Full particulars of every accident are to be furnished by the Employer.
2. The giving of the undermentioned information does not imply that the injured person is making, or will make a claim.
3. This form is sent without prejudice to the terms of the policy.
4. If any details of information are not readily available, please forward this form without delay, and advise the missing details as soon as possible.
5. All written communications received by the Employer concerning accidents to employees should be forwarded at once to the Company.

THE EMPLOYER	
1. Name of Policyholder	
2. Business	
3. Address	
4. No. of Policy	

THE INJURED PERSON	
5. Name	
6. Age & Nationality	
7. Local Address	
8. Whether married or single	
9. State occupation in which injured person is employed	
10. On what work was the injured person engaged at the time of the accident?	
11. Was the injured person actually working when the accident occured	
12. Is the injured person in your direct employ? If not please give name and address of Contractor	
13. When did the injured person enter your service?	
14. If taken to hospital please state :- (a) Name of Hospital (b) Whether still in hospital (c) Whether in or out patient or date of discharge	
15. If not taken to hospital, please state whether being medically attended and if so by whom	
16. Was the injured person free from Physical Infirmity at the time of the accident? If not give particulars	
17. State whether returned to work, and if so, when?	
18. Are you satisfied the injured person has met with a bona-fide accident of employment?	
19. Is the injured person able to do partial work?	
20. What is the probable period of disablement (approximate)?	

THE ACCIDENT		
21. As regards the accident please state	Date: Place:	Time: Date ceased work:
22. Upon what date did you receive notice of the accident and from whom?		
23. Was anyone superintending the work the injured employee was engaged upon? If so, please state name		
24. a) How exactly did the accident occur? b) Has a report been made to the Labour Department?		
25. State nature and region of injury		
26. If the injury was caused by machinery or gearing:- (a) Wether it was fenced or guarded? (b) Was it being cleaned whilst in motion?		
27. What was the general nature of the contract or work going on?		
28. Was the injured person under the influence of drink or drugs at the time of the accident?		
29. Was the injured person guilty of any misconduct or disobedience to orders or rules? If so, please give full particulars		
30. State through whose negligence the accident occured, if any		
31. State the names of any persons who witnessed the accident		

Statement of wages which have fallen due for payment to .... in the employ of .... for 12 months prior to the date of this Accident, or wages earned during such shorter period as he may have been in the Employer's service, stating the date on which he was engaged.

(Note. - The object of this form is to ascertain the exact Monthly earnings of the injured person. It is essential that it should be carefully and correctly filled in. If the injured person has been absent from work at any time during the period of his employment, please state the period and the cause.)

MONTH	WAGE		BONUS, VALUE OF FREE QUARTERS & ANY OTHER ALLOWANCES, & c.	
	$	cts.	$	cts.
TOTAL				
	Total Including All Allowances			

I/We hereby declared the foregoing answers to be true in every respect to the best of my/our knowledge and belief and no information or particulars have been suppressed.

Date, ...

....
Signature of Employer.

NOTE - On receipt of the particulars the Company may, if it so requires, ask for a medical certificate.