

# STATED BENEFITS CLAIM FORM

## 1. EMPLOYER

Name or style of Employer and full address

State (a) Number of Policy

(b) Date of last payment of premium

Nature of Trade or Business

## 2. INJURED WORKMAN

Name

Full address

Occupation  Age  Sex  Married  Single

Was he in your direct employ or in that of a Sub-Contractor?

If in your employ, how long has he been so?

Total earnings for 12 months immediately preceding the accident

State Fully the nature of the work he was doing at the time of the accident

## 3. PARTICULARS OF ACCIDENT

How did it occur?

When did it occur? at  on

State generally the nature of the injuries received

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

State what you consider will be the probable duration of total disablement

Names of Injured  Address

Workman's Medical Attendant  Hospital address

or Names of Nursing  Address

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

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Have you received notification of a Magisterial or other Enquiry?

  
  


If so, state when and where same will be held

Give names and addresses of witnesses of the accident

  


**Accident caused by:** Violation of rules?  Carelessness of injured workman?  Carelessness of any other person?

**If so, who?**

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

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, please state:**

**The date of the Accident**

**Amount of the compensation received**

**MONTHLY EARNINGS AT THE DATE OF THE ACCIDENT**

Cash wage/salary (exclusive of overtime, bonus, payments etc.) Rand

Value of rations

Value of housing

Value of fuel

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

**Total earning per month**

Date

Employer's Signature

**(FOR USE BY THE MEDICAL PRACTITIONER ATTENDING OR EXAMINING THE INJURED WORKMAN)**

Date admitted to hospital

Discharged

In-patient No:

Attendance as out-patient

From

To

Nature of injury

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Permanent incapacity if applicable (report noting the specific impairments, range of motion deficits)

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

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

Date

Medical  
Practitioner

hereby declare that the above statements and particulars are true and correct to the best of my knowledge and belief.

Date

Employer's  
Signature