

SCAL WORKERS COMPENSATION CLAIM FORM

REMINDER

- > It is important that all questions are answered. If not applicable, write 'n/a'.
- > The issue of this claim form is not an admission of liability by SCAL.
- > If there is insufficient space or further comment on any are is considered necessary, please use additional pages.

Employers Details

Name of Employer:
Address of Employer:
Nature of Business:
Telephone:
Facsimile:
Email:

Detail of Accident

> Day of Week:	Date:	Time:
> State exact location where injury was sustained:		
> Did the injured person give notice of injury? (yes/no), to whom was it given?		
Note: If worker failed to give notice of the injury as soon as practicable after its happening, he/she is required to provide a written statement explaining and showing reasonable cause why notice of injury was not given.		
a. When was it given?	am/pm	Date:
b. Give the names of the peron or persons who were actual eye witnesses of the injury:		
> Describe fully the circumstances leading to the accident:		
> What was the nature of injury?		
> If the injury was caused by any person or persons not in your employment, please advise full name and address of those concerned:		

Injured Employees Details

> Name of the injured:					
> Address:					
> Occupation:					
> How long in your employment:					
> Nature of business in which injured was employed in					
> State the operation at which the worker was engaged at the time of accident:					
> a. Was injury sustained in the course of workers employment with you?					
b. Did injury arise out of workers employment with you?					
c. Was the worker in the service of any other employer at that time?					
> Was the worker injured while doing something which he/she was not part of his/her particular employment to do, or was he/she injured at a place or part of the works where he/she was not required to be by his/her particular employment?					
> Schedule:					
Age	Married/Single	# of days worked/week	Average weekly earnings	Date/Time not able to work	Length of time disabled
> Is the injured related to you? If so, what is the relationship and does he or she reside with you?					
> State clearly if injured person is casual, permanent or working under contract:					

Compensation Details

> a. Has the injured person returned to work? (yes/no)			
> b. If so, when?			
> Is compensation being claimed or received from any other reinsurer?			
> Was the injured person free from physical disability at the time of the accident?			
> Are you aware whether the worker has ever previously suffered from a similar injury?			
> Was the part affected by this accident quite normal before the accident? (yes/no)		If "no", please give full details:	
> Would such physical disability have contributed to this accident?			
> If the worker has received any medical, surgical or hospital treatment, please state under which hospital and forward medical receipts if available.			
> a. Name of hospital:			
> b. Whether In-patient/Out-patient:			
> c. Name of doctor:			
> d. Address:			
> e. Telephone:			
> f. Facsimile:			
> g. Email:			
> Details of dependents (<i>to be completed after consultation with employee</i>) .			
Names	Date of Birth	Relation	State whether wholly or partially dependent

Declaration

I/We declare that:

- a. the information and answers given above are correct to the best of my/our knowledge and belief
- b. I/We understand the claim may be refused or reduced if information is withheld

Signature of Employer: _____

Date: _____