

WORKMEN COMPENSATION CLAIM ADVICE



(THE ISSUANCE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY)

Policy No.

Claim No.:

THE POLICY HOLDER:

THE INJURED

1. Name:		2. Male/Female:		
3. Age:	4. Nationality:		5. Occupation:	
6. Insurance List Nr.	7. Salary	Monthly	Daily	8. Work days per week:

THE ACCIDENT

9. Place:	10. Date:	11. Time:	am/ pm
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12. Whether the Police were informed of the accident? (If yes, please enclose Police Report.)	Yes
	No

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

14. Name (s) and address (es):

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

Contd...2

Damaan Islamic Insurance Company – Beema (Q.P.S.C)

CR: 43652 Tel (+974) 44050555 Fax: (+974) 44050505

P.O. Box 11068 Lusail – Qatar, Paid up Capital QR 200,000,000

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15. Has the injured person resumed duty? Yes/No	16. Resumed duty on
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17. Following documents in original hereto attached — please tick (✓) the appropriate

1	Medical Report and Sick leave Certificate (s) due to injury.
2	A copy of document showing name and declared salary as evidence of inclusion of the employee for this Workmen Compensation Insurance with us.
3	Police Report
4	Medical Board's Report on Permanent Disability, if any.
5	Directive from the Department of Labour/Ministry of Interior, for Disability
6	Directive from Court asking you to pay compensation
7	Death Certificate, Copy of Passport/ID/Visa (in death cases)
8	In case of Road Traffic Accident, Traffic Police Report and details of Motor Insurance Policy of the vehicles involved in the accident are required.
9	Others

Date:	Office Name and Seal	Signature of the Insured
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FOR OFFICE USE ONLY

Computation of compensation payable:

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