SALAM TAKAFUL INSURANCE COMPANY LIMITED
65, IBRAHIM TAIWO ROAD, KANO
Website: www.salamtakafulinsurance.com
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EMPLOYER'S LIABILITY CLAIM FORM

Particulars of Accident to be furnished by the Employer

Instruction: Use (✓) where appropriate.

NOTE: Answering these questions does not imply that the Employee admit liability or that the Employee will make a claim.

PART A: POLICY DETAILS

POLICY NO:

Date of payment of last contribution: _ _ / _ _ / _ _ _ _ format dd/mm/yyyy

PART B: THE EMPLOYER

FULLNAME:

ADDRESS:

TRADE/ BUSINESS :

PHONE NO:

HAVE YOU ANY POWER-DRIVEN MACHINERY? YES NO

PART C: THE INJURED PERSON

i- Name:

ii- Address:

iii- Marital Status: Single Married iv- Age:

v- Nationality:

vi- Normal Occupation:

vii- Period in your service:

viii- Is he/she in your direct employ? YES NO

If not, provide contractor details;

Name:

Address:

Authorized and Regulated by:

Member of:

ix- State fully the work upon which he/she was engaged at the time of the accident:

State on the back of this from the earning during the past 12 months.

PART D: DETAILS OF ACCIDENT

i- Date and hour of accident: Time: _ _: _ _ am/pm Date: _ _ / _ _ / _ _ _ _

ii- Place of accident:

iii- Date the injured person ceased work: _ _ / _ _ / _ _ _ _ format dd/mm/yyyy

iv- How did the accident occur?

v- When and to whom did he/she first report the accident?

(a) When? _ _ / _ _ / _ _ _ _ format dd/mm/yyyy

(b) To whom?

vi- State fully the nature of the injuries. If accident happened in connection with any machinery, give name of machine and state part causing accident;

vii- Did the injury result in death? YES NO

If yes, state Date: _ _ / _ _ / _ _ _ _ format dd/mm/yyyy

viii- Was he/she under the influence of drugs or drink or was he/she guilty of any misconduct or breach or orders or rules? YES NO

If yes, please explain fully;

ix- Was the accident due to anyone's negligence? YES NO

If yes, give particulars.

x- Is he/she able to perform any part of his/her duties? ☐ YES ☐ NO

xi- What is the probable period of disablement, in your opinion? ☐

xii- Provide details of witnesses;

Name	Address

PART G: DECLARATION

I/we certify that the above and the wages statement overleaf are true to the best of our/my knowledge and belief.

Employer's signature: _____ Occupation: _____

Date: _____20 ____

N.B: - The wages statement overleaf should be completed if a claim has been, or is likely to be made.

WAGES STATEMENT

WAGES STATEMENT, and (if supplied by the Employer), the value of FOOD, FUEL, and QUARTERS and other prerequisites.

Complete on monthly or weekly bases, ignoring whichever of the first two columns is not applicable.

If paid monthly MONTHLY ENDING	If paid weekly WEEK ENDING	CASH WAGES	Value of Food, Fuel and quarters, and other perquisites	Dates of any absences from work and reasons for absence
1	1 2			
2	3 4			
3	5 6			
4	7 8			
5	9 10			
6	11 12			
7	13 14			
8	15 16			
9	17 18			
10	19 20			
11	21 22			
12	23 24			
TOTAL ON MONTHLY BASIS				
	25 26			
	27 28			
	29 30			
	31 32			
	33 34			
	35 36			
	37 38			
	39 40			
	41 42			
	43 44			
	45 46			
	47 48			
	49 50			
	51 52			
	TOTAL ON WEEKLY BASIS			

THE OBJECT OF THIS FORM IS TO ASCERTAIN THE EXACT AVERAGE EARNINGS OF THE INJURED PERSON. IT SHOULD BE CAREFULLY COMPLETED GIVING THE FIGURES REQUIRED FOR THE TWELVE MONTHS PRIOR TO THE ACCIDENT OF FOR SUCH SHORTER PERIOD AS HE/SHE MAY HAVE BEEN IN YOUR SERVICE.

Authorized and Regulated by:

Member of: