WORKERS COMPENSATION CLAIM FORM

Employers Name:_____

SECTION ONE - TO BE COMPLETED BY THE INJURED WORKER

Name: _____

Address: _____

Job Description:_____ Date of Birth:_____

Date of Accident: _____ Time:_____

Place of Accident: _____

When did you stop work - Date:

_____ Time:_____

When did you resume work - Date: _____ Time: _____

What are you injuries _____

What caused your injuries_____

DO NOT COMPLETE THE NEXT SECTION UNLESS YOU LOST TIME FROM WORK

Do you have any dependants? YES/NO If Yes, please complete the schedule of dependants.

Are you married? _____ Full Name of Spouse _____

Date of Marriage _____ Place of Marriage _____

SECTION TWO – TIME LOST DETAILS

Does your spouse live with you? Yes/No If no, state where_____

Is your spouse totally, mainly, partially dependant upon you? (**Circle one only**)

If have the following dependants, including children under 16 years of age.

Name	Relationship to You	Date of Birth	Place of Residence	Is the person totally dependant upon you. If not, how much?

SECTION THREE - TO BE COMPLETED BY THE EMPLOYER IF TIME LOST

Was the injured worker directly employed by you? YES/NO

If no, state details of employment _____

According to your records, what dependants does the workers have.

Name	Relationship to Worker	Date of Birth	Place of Residence	Degree of Dependancy

State the number of days/hours worked by the insured worker. Days _____ Hrs _____

State work times on day of accident. Start: _____ Finish_____

State amount of earnings at the time of the accident. _____ Ave earnings last year _____

Do you pay any other benefits? Yes/No If Yes, state details _____

Has the injured worker returned to work? Yes/No If no, when do you expect a return? _____

Where can the worker be contacted now?_____

TO BE COMPLETED BY THE EMPLOYER

I/We declare that the information contained in this claim form is true and correct to the best of our/my knowledge.

Signature of Employer_____ Date_____

Pacific MMI Insurance Limited
Level 4, Champion Plaza, Champion Parade, Port Moresby
P.O. Box 331, Port Moresby
Phone: (675) 321 4077 Fax: (675) 321 7898

TO BE COMPLETED BY THE INJURED WORKER

I hereby authorise any hospital, doctor, or other person who has given me medical attention, or my employer to give Pacific MMI Insurance Company or it's representatives, any and all information with regard to any injury or sickness, medical history, or consultation I have previously had. I also authorise the company or it's representatives to obtain full hospital records and employer records as required.

I agree that a photostat copy of this authority is as effective and valid as this original.

And I declare that the information supplied in this claim form is a true and accurate statement in regard to my claim for compensation. I agree to advise my employer if any circumstances in regard to this claim, my dependants or my medical condition should change.

Signature of Worker _____ Date _____

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