



WORK INJURY BENEFIT ACT CLAIM FORM

INTRA AFRICA ASSURANCE COMPANY LIMITED

(Incorporated in Kenya)

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This form is to be completed by the employer in duplicate as soon as practicable after the accident and sent to the agent of the area in which the accident or death occurred.

Agency name: _____

1. EMPLOYER DETAILS

Full name _____

Pin number(please attach copy): _____

Certificate of Registration/Incorporation/ID/Passport(Please Attach copy) _____

Mobile: _____ Email: _____

Postal: _____ Code: _____ Town/City: _____

Web: _____ Fax: _____ Tel: _____

2. INJURED PERSON

Full name _____

Pin number(please attach copy): _____

Certificate of Registration/Incorporation/ID/Passport(Please Attach copy) _____

Mobile: _____ Email: _____

Postal: _____ Code: _____ Town/City: _____

Web: _____ Fax: _____ Tel: _____

Occupation: _____ Age: _____

3. ACCIDENT

Date: _____ Time: _____ Place: _____

Brief Description of cause: _____

State exactly what the injured person was doing at the time: _____

If accident due to machinery, state:

Name of machine and part causing accident: _____

Whether in motion by mechanical power at the time _____

4. INJURIES.

Give brief description of injuries as apparent to employer _____

5. MEDICAL TREATMENT

To what hospital or medical practitioner was the injured person sent for treatment _____

6. EARNINGS OF INJURED PERSON

Give rates at time of accident:

Rates of wages: Daily: Kshs: _____ Monthly: Kshs _____

Value of free ration: _____ Kshs: _____

Value of free housing: _____ Kshs: _____

Value of free fuel: _____ Kshs: _____

Particulars and value of any bonuses or allowances other than above Kshs. _____

7. EMPLOYEES

Number	Occupation	Wages

Do you keep a proper wage book: _____

Was the injured person in your direct employment: _____ Yes/No

If so, since when was he employed: _____

If the injured person was not employed directly by you, name the Sub contractor who employed him:

Does the injured person come within the scope of compensation ordinance: _____

Give particulars of any circular saws or other machinery driven by steam, gas, water or electricity or other mechanical power: _____

Were your machinery, plant and ways properly fenced and guarded, and otherwise in good order and condition?

Were all the conditions, stipulations, warranties of the policy fulfilled by you prior to the accident?

DECLARATION.

I/We hereby declare that all the above statements and particulars, which I/We have read over and checked are true, that I/We have not suppressed or misrepresented or misstated or material fact, which would otherwise liable the claim to be rejected by the Company. I/We further agree to give every assistance in my/our power in dealing with this claim

Signature: _____ Date: _____

Submission or issue of this claim form does not bind the company of any admission of liability