SERENE INSURANCE COMPANY LIMITED

Head office: First Sky Tower, Com 25 Junction, After Kpone Barrier
P.O. Box PMB CO 90, Tema, Ghana
Telephone No. 0302-917444/6/7

WORKMEN'S COMPENSATION CLAIM FORM

INSURED_____ TRADE OR BUSINESS_____

POLICY NO.: _____ADDRESS_____

DETAILS OF INJURED WORKER

1. (a) Full Name:_____

   (b) Address:_____

   (c) Occupation_____ (d) Job Description:_____

   _____

   (d) Age:_____Marital Status:_____

   (e) Amount of weekly earnings:_____

   (f) How long has he continuously been in your employment?_____

2. Date of accident:_____ Time:_____
   Place:_____

   State the work that the workman was engaged in at the time of the accident.

   Was the injured worker under the influence of alcohol or any drug? YES / NO

3. (a) Date on which injured worker ceased work consequent upon the accident:_____

   (b) Date of resumption of work:_____

4. Please give a full description of how the accident happened:_____

_____

_____

_____

5. (a) Please state the exact nature of injuries sustained by the worker_____

_____

(b) Was the accident caused by the negligence of the injured worker or his/her co-worker?

YES / NO, If yes, please explain_____

_____

(c) Names and addresses of witnesses:_____

_____

I/We declare that the above statement is true in all respects to the best of knowledge and belief and we undertake to give all information and assistance as the company may require.

Name & Signature of Policyholder

Signature: _____Name:_____Date:_____

If you have any reason to contact our Regulator, you may reach them at the address below:

Insurance Place
Independence Avenue
P. O. Box CT 3456
Cantonments, Accra
Ghana

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