Workmen's Compensation Benefits

Claim Form

If you are signing for someone else, include a copy of the durable power of attorney or executorship if not previously provided.

Important information

The issue of this form is not to be taken as admission of liability. If any detail / information is not readily available, please do not delay dispatch of the report.

General Information

1. Policy No.: _____
2. Company name: _____
3. Address:
   - PO Box: _____
   - P.C: _____
   - Fax: _____
   - Phone No.: _____
4. Name of Life Assured: _____
5. Serial / employee No. / Staff No.: _____
6. ID No.: _____
7. Occupation of the Life Assured: _____
8. Was he/she on official duty? ❑Yes ❑No
9. Date of appointment in service? _____
10. Date of accident: _____
11. Time of accident: _____
12. Cause of accident: _____
13. Name of hospital: _____
    In or out patient? ❑In ❑Out
14. Date of admission From:_____ To:_____
15. Monthly salary (OMR): _____

16. Sick leave dates	Claim Amount (OMR)	Remarks
From:		
To:		
Medical Bills (original cash bills) total		
Others (PTD/PPD Accident)		
Total Claim amount		

In order for us to process this request, please sign below and return.

Sign Here	Signature	Date *(DD/MM/YYYY)*

How to submit this form

To finalize the payment process, we require the submission of the original documents

Note: Attach the following to this Claim Form

- Original accident certificate
- Hospital report showing cause of accident
- Police reports in case of accident / unnatural events
- Sick leave certificate
- Copy of Labour card (Valid)
- Copy of passport / visa page
- Claim details in case of accident in foreign country
- Salary list
- Original medical bill (with proof of payment)

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