

CLAIM APPLICATION FORM FOR EMPLOYEE'S COMPENSATION INSURANCE

(The issue of this form is not to be taken as an admission of liability)

Office Address:	Cover Note / Policy No : Period of Insurance : Date of Accident : Claim Number :
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This will be in continuation of the Incident Reporting Form dated

This form is only for the purpose of intimating the Company about the claims made / seeking the permission of the Company to enter into a settlement. Insured shall not enter into settlement without the prior written permission of the Company. The completion and return of this form to the Company should not be delayed even if any of the particulars required cannot be immediately given. They may be forwarded to the Company afterwards as soon as possible.

Please answer all questions fully

1. Details Of Insured	
(i) Name (ii) Address for correspondence (iii) Contact Number (iv) E mail ID	
2. Details of the Injured Person	
(i) Name (ii) Age and sex (iii) Residential Address	_____Yrs ☐ Male ☐ Female
3. Details of occupation	
(i) What is the occupation in which the injured person is employed?	
(ii) Was the injured person engaged in this occupation when the accident occurred? (iii) If not state fully the nature of the work he was doing at the time of the accident?	☐ Yes ☐ No

4. Details of employment	
(i) Is the injured person in your direct employment? (ii) If not give name and address of Contractor?	☐ Yes ☐ No
(ii) When did the injured person enter your service?	Date
5. Details of the Accident	
(i) Date and time of accident.	Date----- Time-----
(ii) Place of accident.	
(iii) Give brief description of the accident?	
(iv) Was the claimant at the time of accident in the course of employment. If yes, state details.	☐ Yes ☐ No
(v) Was the injured person under the influence of alcohol or other intoxicant at the time of the accident?	☐ Yes ☐ No
(vi) Was he guilty of any misconduct or disobedience to orders / rules, due to which incident occurred? If so, please give full particulars.	☐ Yes ☐ No
(vii) Are you satisfied that the injured person has met with a bona-fide accident of employment?	☐ Yes ☐ No
6. Details of Injury	
(i) Give a brief description of injury?	
(ii) What is the % of disability if any? Attach a certificate of doctor confirming disability?	-----% _____Days
(iii) What is the probable period of the disablement?	
7. Details of Hospital	
(i) Has the injured person been removed to hospital or medically attended?	☐ Yes ☐ No
(ii) If yes, give name and address of	

hospital attending to injured person?	
(iii) Date of admission in hospital	Date: -----
(iv) Date of discharge from hospital.	Date: -----
8.(i) Whether injured person has returned to work?	☐ Yes ☐ No
(ii) If yes, then the date of return and no. of days of absence?	Date ----- Days -----
9. Court Procedure	
(i) Has any case been filed in any court of law/tribunal against you, in relation to the accident?	☐ Yes ☐ No
(ii) Have any notices / summons of the court been received by you? If yes, please provide copies of the same.	☐ Yes ☐ No
(iii) Date and time of receipt of notice/summons from the authorities	Date----- Time-----
(iv) What is the present status of the proceedings? Also give the next date of hearing.	
(v) Provide copies of all the documents that have been submitted to the Court either by you or the employee/claimants, and copies of all the documents received with the notice from the court.	
(vi) Has the court passed any interim or final order? If yes, please provide copies of the same.	☐ Yes ☐ No
(vii) Has the subject matter of the alleged claim/complaint been earlier reported to the Company by an Incident Reporting Form? If yes, please provide date of Incident Reporting Form, and append copy	☐ Yes ☐ No Date-----

thereof	
(viii) If no, kindly submit a duly completed Incident Reporting Form / or set out here the Insured's views/comments on the alleged incident which has resulted in the alleged claim or complaint arising.	
(ix) The Insured's proposed response to the alleged claim/complaint?	
(x) Does the insured propose to/has already availed of, any legal advise.	☐ Yes ☐ No
(xi) If Yes, details of the lawyer/law firm together with their opinion.	
(xii) If No, the proposed steps by the Insured to evaluate the legal liability risk in the context of its response/proposed response and the facts having bearing on the matter.	
10. Miscellaneous	
(i) Details of claims if any preferred by the affected party / claimant for the same loss from another source.	
(ii) Any other evidence in support of claim.	
(iii) Give particulars of any other insurance, in respect of the same risk.	
(iv) Give name and address of witness if any?	
Are you or any of the proposed applicants/beneficial owner a PEP* or Family member/Close relatives/Associates of PEP*? Yes ☐ No ☐	

If yes, please give details (Nature of relationship and position held by PEP:

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"Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States / Government, senior politicians, senior government / judicial / military officers, senior executives of state-owned corporations and important political party officials;"

I/We, the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect; and I/We agree that if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, my/our claim shall be absolutely forfeited, and the Policy shall be null and void.

I/We hereby give my/our consent to the Company to verify and obtain my/our identity/address proof as well as the identity /address proof of the insured / beneficial owner through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

Receipt and/or acceptance of the "Consent / Claim Application Form" shall not constitute or deem to constitute an approval for a settlement in terms of this clause and the Company reserves the right not to grant the permission.

Place:

Date:

Signature of Insured:

Claim Clause/ Settlement of Claim:

1) Claim Intimation: Connect with us via: Toll-free no.: 1800 2666,

Email ID: customersupport@icicilombard.com, on our website:

<https://coclaims.icicilombard.com/claimstracker/CommercialClaims/ccplandingpage.aspx>

Register the claim and submit claim related documents along with claim form. You will receive a claim reference number as your reference point for future correspondence.

2) File an FIR: In case of third-party property damage/bodily injury, fire etc. if applicable as per policy terms and conditions.

3) Surveyor Appointment: Your Claims Manager (CSM) will contact you and appoint a licensed surveyor basis claim eligibility within 24 hours of reporting the claim

4) Documents: submit documents to the assigned CSM/Surveyor.

List of documents which are necessary and relevant to the claim are as below:

1. Claim bill / Claim Form duly filled up
2. Photographs / Video of damaged property/item under claim
3. Document/s in support of admissibility of the claim, for instance, Service Engineer's Report, Fire Brigade Report, etc.
4. FIR / Final Police investigation report wherever applicable
5. For items which are to be repaired or reinstated, repair/ replacement quotation, invoice and payment proofs for each and every item as claimed.
6. For items which are under claim & not to be repaired or reinstated, documents substantiating the quantum & value of the items under claim
7. Offer for retention of salvage, if any
8. KYC / NEFT Details as per AML guidelines
9. Invoice copy / Goods Receipt Note / Monetary Claim on carrier / Damage Certificate
10. Any other document which may be specified by the surveyor post completion of initial survey

5) Assessment Approval: Repair/Replacement details submitted in support of the claim will be assessed and approved by CSM/surveyor

6) Salvage: The amount that is assessed which the damaged asset will fetch in the open market (wherever applicable).

7) Turnaround Time (TAT): Assessment sheet /Survey report will be furnished within 15 days of receipt of claim form and documents. Claim will be decided within 7 days of receipt of the assessment sheet / survey report (This condition will not apply in case of policies issued on the property/building on reinstatement value basis).

Statement of Wages

The object of this statement is to ascertain the injured person's average monthly earnings. Please therefore observe the following instructions very carefully. Failure to do so will entail unnecessary correspondence and cause undue delay in the settlement of the claim.

1. If the injured person has been in the service during a continuous period. (not broken by an absence of 14 or more consecutive days) of 12 months or more, then enter the wages etc. paid to him in each month during 12 months immediately preceding the accident.
2. If he has been in the service during a continuous period of less than 12 months but more than a month then enter the wages etc. paid to him in each month during such period immediately preceding the accident.
3. If he has been in the service during a continuous period of less than one month, then enter the wages paid to another employee employed on similar work during 12 months immediately preceding the accident i.e. accident to the employees in respect of whom the claim is being submitted.
4. If you have no employee employed on similar work and for 12 months then enter the wages etc. paid to the injured employee himself during whatever period of service he has put immediately preceding the accident.
5. Please specify the period for which wages have been entered in this statement by mentioning the date of the beginning of the period and the end of the period which should be the date prior to the date of accident.
6. Please do not mention merely the rate of wages. Give full details as above.

Month	Wages		Bonus Value of Free Quarters and Any Other Allowances and	
	Rs	Period	Rs	Period

Total				
	Total including all Allowances			

(a) Were the above stated wages paid, or fallen due for payment, to the injured person?

(b) Was the injured person absent from work at any time, during the above stated period, for 14 or more consecutive days?-----

If so, give the following particulars:-

Absent for ----- days from----- to-----

Date ----- 20__

Signature of the Employer

ICICI Lombard General Insurance Company Limited

Mailing Address: 601 / 602, 6th Floor, Interface Building No.16, New Link Road Malad (W), Mumbai - 400 064.

Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.

Visit us at www.icicilombard.com • Mail us at customersupport@icicilombard.com

Toll Free No.: **1800 2666** • Chargeable No.: **+91 86552 22666** • Insurance is the subject matter of solicitation.

IRDA Reg. No. **115** • CIN: **L67200MH2000PLC129408**