CLAIM No.....

GENERAL ACCIDENT INSURANCE CO. KENYA LTD.

NOTIFICATION OF INJURY TO AN EMPLOYEE

This form is to be filled up and sent to the Company immediately the accident comes to the Employer's knowledge.

WORKMEN'S COMPENSATION

EMPLOYER: (1) Name or style of Employer and full address	
(2) State (*a*) No. of Policy . . . . (*b*) Date of last payment of Premium .	
(3) Nature of Trade or Business	
INJURED EMPLOYEE: (4) Name and full Address	
(5) (*a*) Occupation ? . . . . . (*b*) Age ? . . . . . (*c*) Married or Single ?	
(6) Is the injured Employee related to the Employer? If so, what is the relationship ?	
(7) Was the Injured Workman in the employ of the Insured or in the employ of a Contractor ? . . . . . If the latter. Name and Address of the Contractor and nature of contract . .	
(8) Was the Injured Workman's employment **casual or regular?** . . . . . If the former, state how often employed . If the latter, state how long he had been employed by you or such Contractor prior to the Accident	
(9) (*a*) Give rate of pay at time of Accident. (State whether per day, week or month). . (*b*) State value of food and for housing per month	
(10) If apprentice, learner or improver, state his terms of remuneration to end of apprenticeship and how much he might then expect to earn	
(11) State *fully* the nature of the work he was doing at the time of the Accident . .	
(12) How did the Accident occur ? . . .	
(13) Where did the Accident occur ? . .	
(14) When did the Accident occur ? . . .	HOUR At ..... m. on the ..... day of ..... 20 ....
(15) Give names and addresses of witnesses of the Accident	
(16) Was the Accident caused by:— (*a*) Violation of rules ? . . . . (*b*) Carelessness of injured Employee ? . (*c*) Any defect of machinery or plant ? If so, had such been brought to your notice ?	

(17) Was the injured person sober at the time of the Accident? . . . . . Under whose direction was he at the time of the Accident? . . . . . Was the Accident caused by carrying out such direction?	
(18) Was the injured person suffering at the time of the Accident from ill-health or bodily defect or infirmity of any description?	
(19) Were you aware of such ill-health, defect or infirmity?	
(20) Has the injured person previously received compensation for an accident sustained either whilst in your service or in that of a previous employer? If so, please state: *(a)* The date of the Accident . . . . . *(b)* The amount of the compensation received	
(21) State as fully as possible the nature of the injury received.	
(22) State to what extent the injured person is disabled and whether absolutely prevented from following his employment	
(23) State what you consider will be the probable duration of total disablement. NOTE:— It is important that the fullest possible information be given under this head.	
(24) Give name and address of the injured workman's Medical Attendant . . . . . If in Hospital, give name of same	
(25) At what hour and on what date was the injured first attended to by a Doctor? . . .	
(26) Have you received notification of a Magisterial Enquiry, or of intention to institute any legal proceeding? . . . . . If so, give full particulars	

I/WE hereby certify that the above Statement is a full and true account to the best of my/our knowledge and belief, and I/WE undertake to advise the Company promptly of all developments in connection with the claim.

Dated this.....day of.....

Employer's Signature.....

Notice to Employer:— It is a condition of your Policy that no payment must be made, nor any liability admitted, in respect of Accidental Injury to an Employee, until ordered by the Court, or authorised by the Company.

Certificate to be filled up and Signed by an Eye Witness, if possible by the person under whose direction the Workman was at the time of the Accident.

I hereby certify that I was present when the accident occured to.....

on the.....day of.....and that it happened in the following manner:—

Signature.....

Occupation.....

Date.....