Workmen's Compensation Claim Form

NATIONAL
INSURANCE COMPANY BERHAD
In association with Allianz

Email
claims@national.com.bn

BSB Office No.
+673 222 6222

KB Office No.
+673 333 1222

Reminder

1. The policyholder must give full and correct information.
2. The company will not entertain any claim if the information given is incomplete.
3. Acceptance of this notification does not construe any admission of liability or waiver on the part of the company of any breach of the conditions the insured may have breached.
4. In the event of any occurrence which may give rise to a third-party claim, no admission, offer, promise or payment shall be made by or on behalf of the insured without the written consent of the company. All correspondence made by the third party must be forwarded to the company immediately unanswered.

Purpose of Notification

☐ Report for information only	☐ Insurance Claim

Claims Section

☐ Workmen's Compensation	☐ Personal Accident
☐ Hospital & Surgical Expenses (Illness)	☐ Death

Policy Details

Policy Number	

Policyholder's Details

Policyholder Name			
Contact Number	(M)	(O)	(H)
Email Address			

Worker's Details

Worker's Name			
Identity Card Number			
Passport Number			
Contact Number	(M)	(O)	(H)
Email Address			

Documents Required to be Submitted

- ☐ Copy of Injured Worker's Valid Identity Card
- ☐ Copy of Injured Worker's Passport with Valid Work Pass Stamped
- ☐ Copy of Valid LD / Amah Quota
- ☐ Copies of Salaries Vouchers (Past 6 Months)
- ☐ Medical Sick Certificates (If any)
- ☐ Medical Bills
- ☐ Discharge Ticket (If Worker was admitted)
- ☐ Bur A Form – If reported to the Labour Department

Workmen's Compensation

Date of Loss	Time of Accident	Nature of Injury
Place of Accident		

Was the Injured worker engaged in his / her occupation?	☐ Yes ☐ No
Has the Accident ben reported to the Labour Department? ***If yes, please enclose a Copy of the Bur A Form**	☐ Yes ☐ No
Detailed Statement of the Incident / Accident	

Documents Required to be Submitted

- ☐ Copy of Worker's Valid Identity Card
- ☐ Copy of Worker's Passport with Valid Work Pass stamped
- ☐ Copy of Valid LD / Amah Quota
- ☐ Medical Bill(s)
- ☐ Discharge Ticket (*if admitted*)

Personal Accident

Date of Loss	Time of Accident	Nature of Injury
Place of Incident		

Detailed Statement of the Incident / Accident

Documents Required to be Submitted

- ☐ Copy of Worker's Valid Identity Card
- ☐ Copy of Worker's Passport with Valid Work Pass stamped
- ☐ Copy of Valid LD / Amah Quota
- ☐ Medical Bill (Admission)
- ☐ Discharge Ticket Summary

Hospital & Surgical Expenses (Illness)

Date of Onset	Nature of Claim	Name of Hospital
Date of Admission		
Date of Discharge		

Documents Required to be Submitted

- ☐ Copy of Worker's Valid Identity Card
- ☐ Copy of Worker's Passport with Valid Work Pass stamped
- ☐ Copy of Valid LD / Amah Quota
- ☐ Medical Bill(s) / Repatriation Bill(s)
- ☐ Death Certificate / Autopsy Report

Death

Date of Death	Time of Death	Place of Death
Cause of Death		

Payment Details

Please note that payment will be made to you via online payment.
Kindly provide us with your banking details as follow:

Payee / Beneficiary's Name	
Payee / Beneficiary's Account Number	
Payee / Beneficiary's Bank Name	
Payee / Beneficiary's Address	
Payee / Beneficiary's Identity Number	

Declaration by the Policyholder

I/We to the best of my/our knowledge hereby declare that the above statements and particulars are correct and complete in every respect and I/We have not concealed, misrepresented or mis-stated any material fact.

I/We agree that if such statements and particulars were filled in by any other person, such person shall be deemed to have been my/our representative for the purpose of filling in the statements and particulars shall be binding upon me/us.

I/We hereby agree to give my/our fullest cooperation to the Company or it's representative in relation to this claim.

I/We hereby consent to use of the particulars and information for the dominant purpose of obtaining legal advice in relations to this claim.

_____

Policyholder's Signature and / or Company Stamp
Date:

For Claims Department Use

Received by National Insurance Company Berhad, on _____ by _____.