انشورانس كومباني ليمتد
ص.ب. ١٥٢، دبي، اع م
هاتف: ٣٦١٩٧٧٧ (٠٤)
فاكس: ٣٦١٩٨٨٨ (٠٤)
http://www. tmnf.ae/

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NICHIDO

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(Incorporated in Japan, registered in the Insurance Companies register under Regn. No. 45 dated 29th December 1984)
AGENTS FOR UNITED ARAB EMIRATES: AL FUTTAIM DEVELOPMENT SERVICES CO. LLC.

Notice Of Injury Form

The Employer's attention is particularly drawn to the fact that his interests and those of the Companies identical in as much as the future premiums payable naturally depend upon the amount of claims paid by the Companies. He should therefore do everything possible to prevent any but bonafide claim being admitted to benefit under the policy and to get the injured person back to work as soon as reasonably possible.

	THE INJURED PERSON	
1	Name	
	Date of birth &Age	Date of Birth : Age : Years
	Employer	
	Address	
	Designated Occupation	
	Period of Service	
2	Is he/she in your direct employment? If not give name & address of the contractor	
3	State fully the work upon which he/she was engged at the time of the accident.	
4	Basic wage rate per month or per hour: state whether entitled to paid holiday after every 6 days of work. (state the earnings during the past 12 months on reverse of this page)	
	THE ACCIDENT	
5	Date , time and place	Date : Time :
6	Date the injured person ceased to work	
7	How did the accident occur ?	
8	When & whom did he/she first report the accident?	
9	Is this accident repoertable under any Factories Act or Similar legislation? N.B. Please ensure that you have complied with your obligations in this respect.	
10	State names of any witnesses.	
11	State the nature of injuries.	
12	What medical attentionis he/she receiving?	
13	was he/she under the influence of drugs or other introxicating substances?	
14	Was he/she guilty of any misconduct or breach of orders or rules? If so please explain fully.	
15	was the accident due to any one's negligence? If so give particulars.	
16	What is the probable period of disablement in your opinion?	
17	Please provide any other information relevant to this accident. Please attache extra page(s) if space insufficient.	

I/We hereby certify that the above information and the wages statement overleaf are true to the best of my knowledge and belief and that I/we have not concealed or withheld any facts of information.

Employer's Signature : Date :-----------------------------
Address :
Designation :
Workmen's Compensation Policy No. Dated :

WAGES STATEMENT

SALARY DETAILS :

MONTH	BASIC SALARY	DEARNESS ALLOWWANCE	TOTAL SALARY
JANUARY			
FERBRUARY			
MARCH			
APRIL			
MAY			
JUNE			
JULY			
AUGUST			
SEPTEMBER			
OCTOBER			
NOVEMBER			
DECEMBER			

Employer's signature : ______________________________

Designation : ______________________________