TAKAFUL IKHLAS GENERAL BERHAD (1233870-A)
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(Licensed under Islamic Financial Service Act 2013
and regulated by Bank Negara Malaysia)

NOTICE OF CLAIM
Workmen's Compensation Insurance

N.B. -
1. This form is sent without prejudice to the terms and conditions of the Certificate.
2. The giving of the undermentioned information does not imply that the injured person is making, or will make a claim.
3. If any details or information are not readily available, please forward this form without delay and supply the missing details as soon as possible.
4. All written communications received by the Employer concerning the accident the employee should be forwarded at once to the Company.

A. PARTICULARS OF EMPLOYER

1 . Name of Participant

2 . Address

3 . Business : _____ **4 . Certificate No :** _____

B. THE INJURED PERSON

1 . Name

2 . Address

3 . Age : Years **4 . Sex** : Male Female

5 . I/C No New - - Old

State occupation in which the injured person is employed.	
Was the injured person engaged in this occupation when the accident occurred ?	
Is the injured person in your direct employ ? If not, give name and address of Contractor.	
When did the injured person enter your service ?	
Name of hospital taken to In or out patient State whether still in hospital, or when discharged.	
Has the injured person been medically examined ? If so, please send report. If not, was free medical examination offered ?	
Are you satisfied the injured person has met with a bona-fide accident arising out of and in the course of his employment ?	
Was the injured person under the influence of drink or drugs at the time of the accident ?	
Was he guilty of any misconduct or disobedience to orders or rules ? If so, please give full particulars.	
State through whose negligence, if any, the accident occurred .	
State whether returned to work, and if so, when.	
Is the injured person able to do partial work ?	
What is the probable period of disablement (approximate) ?	

C. ACCIDENT

1 . Date ☐☐☐☐☐☐☐☐ **2 . Time** ☐☐☐☐ a.m/p.m **3 . Place** ……..

State cause and circumstances of accident …….
……
……

On what date did you receive notice of accident and from whom ? If in writing, please attach to this form.	
On what date did the injured person actually cease work ?	
State the names of any persons who witnessed the accident.	
If accident was due to machinery or gearing, please state : a) Whether it was fenced or guarded ? b) Was it being cleaned whilst in motion ?	
What was the general nature of the contract of work going on ?	
Has the accident been reported to the Commissioner of Labour or Commissioner of Police or SOCSO ? State when and where and SOCSO No.	

D. INJURY

State nature of injury.	
State regions injured.	
State right or left side.	

ADDITIONAL PARTICULARS FOR FATAL CASES ONLY

Has the deceased any dependents ?
State names, addresses, sex, relationship ages and occupations (if any)

a) ……
b) ……
c) ……
d) ……
e) ……

In connection with fatal cases, please forward a copy on the Police Report together with a copy of the Death Certificate Burial Permit and Post Mortem Report.

Statement of wages of the injured person earned **in the present employment** for the six months immediately prior to the date of this Accident, or wages earned during such shorter period as he may have been in the Employer's service, stating the date on which he was engaged.

Note :- The object of this form is to ascertain the exact Monthly earnings of the injured person. It is essential that it should be carefully and correctly filled in. **If the injured person has been absent from work at any time** during the period of his employment, please state the period and cause.

YEAR	MONTH	WAGE		Bonus, Value of Free Quarters, and any other Allowances, etc.	
		RM	cts	**RM**	cts
	TOTAL				
		TOTAL INCLUDING ALL ALLOWANCES			

I/We solemnly declare that the foregoing particulars are true and correct in every respect.

Date……20…….

……..
Signature of Employer

POLICY HOLDERS ARE REQUESTED NOT TO OBTAIN MEDICAL CERTIFICATES WITHOUT REFERENCE TO THE COMPANY

Following discussions between the Labour Department, Treasury and Insurers, it has agreed that where medical certificates given under provisions of the Workmen's Compensation legislation in the Federation of Malaya are required by the Commissioner for Workmen's Compensation, whether on behalf of the workman or his own motion, no fee shall be chargeable for such certificate.
This means that when the Commissioner for Workmen's Compensation requires any certificate he can send the injured workman to claim needs the support of medical evidence.
This implies that all medical certificates other than those ordered by the Commissioner for Workmen's Compensation or by the Commissioner for labour on his behalf, must be paid for by the employer.
As your certificate indemnifies you completely in respect of your liability under the Workmen's Compensation legislation, the medical fee charged is recoverable from us; this being so, we shall obliged if you do not ask for medical certificate unless we request you to do so.