WORKER'S COMPENSATION CLAIM FORM

Name of Employer:_____

1. Address of Employer:_____
2. Injured Person(s) Name:_____
3. Injured Person(s) Job Title (description of usual duties):_____

_____

4. Date of accident:_____
5. Where did the accident occur?:_____
6. Date and to whom accident was reported?:_____
7. a) At what time did the accident occur?:_____

   b) Was the Injured Person(s) acting in the course of his employment at the time of the accident?:_____
8. How did the accident occur?:_____

_____

_____

9. Statement from witness(es) (attach separate sheet if necessary):

_____

_____

_____

_____

10. Nature of injury (note that forms BL43/02, BL43/03, BL43/04B & BL43/10 must accompany this claim form)

_____

11. Steps taken to prevent a re-occurrence:_____

_____

Thereby warrant the truth of the above statements

Manager's Signature: _____

Date: _____

Company Stamp:

Mayfair Insurance Botswana Proprietary Limited, Plot 64511, Fairgrounds, First Floor Mmila Building, Gaborone, Botswana
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