شركة بنك الدوحة للتأمين المحدودة
Doha Bank Assurance Company LLC
A 100% owned subsidiary of Doha Bank

WORKMENS COMPENSATION ACCIDENT DECLARATION

Claim No.
Policy No.

EMPLOYERS NAME

DETAILS OF THE INJURED PERSON

1. Name:_____2. Occupation: _____

3. Nationality: _____ 4. Age: _____5. Gender: _____ 6. Marital Status _____

7. Salary: _____ per day/ per month.

DETAILS OF THE ACCIDENT:

8. Place: _____ 9. Date: _____ 10. Day: _____11. Time: _____ a.m./p.m.

12. Circumstances and description of the accident: _____

_____

_____

13. Name and Address of the persons involved in the accident _____

_____

_____

14. Name and address of the witnesses: _____

_____

15. Nature & Extent of Injury (Or sickness): _____

16. Probable duration of disablement: _____

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MEDICAL TREATMENT

17. Name and address of doctor by whom treatment was given _____

_____

18. Has the injured resumed his work:_____ When:_____

Date: _____ _____

Signature of the Insured or his Representative

FOR OFFICE USE

Period of TTD From _____To_____	_____
No. of Days of Disability _____	_____
Amount of TTD Benefit _____	_____
% of PPD & Amount of Benefit _____	_____
Total _____	_____
Remarks _____	_____