WageCare Claim Form

Name of Company/Client: _____

Address: _____

Phone: _____ Email: _____

Policy No.: _____

SECTION 1 – TO BE COMPLETED BY WORKER:

Name: _____

Address:_____

Date of Birth: _____

Job Description: _____

Date of Accident: _____ Time : _____

When did you stop work?_____

When did you resume work? _____

What are your injuries? _____

Name and address of the Doctor/Hospital visited: _____

I hereby authorize any hospital, doctor, or other person who has given me medical attention, or my employer to give FijiCare Insurance Limited or its representatives, any and all information with regard to any injury, medical history, or consultation I have previously had. I also authorize the Company or its representatives to obtain full hospital records and employer records as required.

I agree that a Photostat copy of this authorization is an effective and valid as this original.

And I declare that the information supplied in this claim form is true and accurate statement in regard to my injury.

SIGNATURE OF THE WORKER: _____ **DATE:** _____

SECTION 2 – TO BE COMPLETED BY EMPLOYER

Was the injured worker directly employed by you? Yes/No. If No, state details of employment:

_____

Average Weekly Earnings: _____ Hours worked per day: _____

Hours worked per week: _____ Rate of Pay per hour: _____

How long has the worker been employed by you? _____

Was the worker actually employed at the time of accident? _____

Was the accident reported to you or the worker's supervisor at the time of occurrence? _____

What was the worker doing at the time of the accident? _____

Cause of the Accident? _____

Nature of injuries? _____

Did the worker continue working after the accident? _____

If no, state the time the worker ceased work: Date: _____ Time: _____

In your opinion, was the injury due to negligence, direct or indirect? If so, state by whom and the nature

of such negligence: _____

Was the injury due to the serious and willful misconduct of the worker? _____

Was the worker sober at the time of the accident? _____

I/We declare that the information contained in this claim form is true and correct to the best of my/our knowledge.

SIGNATURE OF EMPLOYER: _____ **DATE:** _____

COMPANY STAMP:

_____