WCIF 14

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ACCIDENT PREVENTION & WORKER'S COMPENSATION SCHEME (S.I. 68/1990)

EMPLOYER'S REPORT OF AN ACCIDENT TO A WORKER
CLAIM FORM

CLAIM FORMS ARE TO BE SUBMITTED WITHIN 14 DAYS OF THE OCCURRENCE OF THE ACCIDENT

NSSA DATE STAMP	

CLAIM NO _____

THIS CLAIM FORM MUST BE COMPLETED IN FULL AND SENT TO THE NEAREST NSSA REGIONAL/ SUB OFFICE

SECTION [A] BELOW TO BE COMPLETED BY EMPLOYER, OR AUTHORISED AGENT

SECTION [B] BELOW TO BE COMPLETED BY WORKER/REPRESENTATIVE

SECTION [A]

DATE OF ACCIDENT	TIME OF ACCIDENT

EMPLOYER: Name _____ SSR No _____

Trading as _____

Postal Address _____

_____

_____

Email: _____

Telephone No. _____ Cell No. _____

If the worker is not in your direct employ, give name and address of the sub-contractor.....

.....

.....

.....

.....

WORKER: Surname | Other names

National Registration Identity Number | SSN

DATE OF BIRTH	SEX	MARITAL STATUS	NATIONALITY

Worker's Residential Address

Email Address | Cell No.

Occupation | Date of Employment

SPOUSE (S) DETAILS

SURNAME	FORENAMES	DATE OF BIRTH	I.D. NUMBER	SSN (if any)	DATE OF MARRIAGE

DETAILS OF CHILDREN UNDER 19 YEARS

SURNAME	FORENAMES	SEX	DATE OF BIRTH

Prior to the accident, has the worker had any physical defect, suffered from any serious illness or received compensation for permanent disablement? [Yes/No].

If Yes give full particulars:.....

.....

EARNINGS:

Basic monthly earnings	For Official Use

Normal working hours

FROM	TO

Nature of work performed .....

PLACE OF OCCURRENCE

a) Full physical address of property or place at which accident occurred:

.....

.....

b) Description of site of accident: examples, workshop, road, building site:

.....

.....

c) Mine accident: state on surface or below surface.

.....

.....

Details of how accident happened

(Give a brief description).....

.....

.....

When was accident reported to immediate supervisor? Date..... Time.....

Period when worker was off duty due to incapacitation: From..... To.....

Light duty period: From.....To.....

Percentage of work performed while on light duty.....

During period of incapacity worker received full / part salary . State Amount.....

Was any safety rule deliberately disobeyed? Yes ☐ No ☐

EMPLOYMENT HISTORY [For loss of hearing and Pneumoconiosis only]

	Name & Address of Employer	Period of Employment		Nature of Work	Whether or not a Noisy/ Dusty Occupation
		From	To		
1					
2					
3					
4					
5					
6					

When was loss of hearing first diagnosed

D D	M M	YYYY

Other relevant medical or working history.....Y/N

If yes, state the history.....

INJURIES

Part of body injured.....

Fatal..... Y N

Is employer claiming for funeral expenses? Y N

Percentage Disability [if known].....%

INVESTIGATIONS

Was the action of the injured worker in line with his/her duty Y N

If NO please explain .....

.....

In case of road accident/assaults please indicate name of police station.....

EMPLOYER'S BANK DETAILS

BANK..... BRANCH.....

ACCOUNT NUMBER.....

THIS DECLARATION MUST BE COMPLETED AND SIGNED BY THE EMPLOYER'S AUTHORISED OFFICIAL

I declare that I am the employer/authorised agent and that to the best of my knowledge and belief the above statements are true.

Full Names in Capital.....Signature.....Date.....

Position in Business.....

OFFICIAL DATE STAMP

SECTION [B]

DECLARATION BY WORKER REPRESENTATIVE

I do hereby agree with the above recorded statements.

Full Names in Capital.....Worker Representative.....

Date..... SIGNATURE.....

SECTION [C]

DECLARATION BY WORKER

PAYMENT INSTRUCTIONS (Tick Relevant box and Supply Details)

☐ Collect from NSSA (For once off payments only) - Your contact address and Telephone Number.....

.....

.....

☐ Bank Deposit-Name of Bank/Building Society/Post Office.....

.....

Account Number.....Branch.....

☐ Post cheque to Claimant's postal address as follows.....

.....

☐ Collect from Post Office-Please state name of Post Office preferred:.....

.....

DATE.....WORKER'S SIGNATURE.....