

Botswana Insurance Company Limited

GABORONE OFFICE

P.O. Box 715 Gaborone, Botswana
BIC House
Plot 50372, Gaborone Business Park,
Gaborone Show Grounds,

GABORONE

Tel: (267) 3600 500,
Fax: (267) 3972 867

FRANCISTOWN OFFICE

Botswana Insurance House
Plot No. 454/5
St. Patrick Street
P.O. Box 451

FRANCISTOWN

TEL: (267) 2413 623
FAX: (267) 2412 291

WORKMENS COMPENSATION CLAIM FORM

1. NAME OF EMPLOYER.....
2. ADDRESS OF EMPLOYER
3. INJURED PERSON(S) NAME.....
.....
4. INJURED PERSON(S) JOB TITLE (DESCRIPTION USUAL DUTIES)
5. DATE OF ACCIDENT.....
6. WHERE DID THE ACCIDENT OCCUR?.....
7. DATE AND TO WHO ACCIDENT WAS REPORTED?
8. a. AT WHAT TIME DID THE ACCIDENT OCCUR?
- b. DID THE INJURY OR INJURIES ARISE OUT OF AND IN THE COURSE OF EMPLOYMENT?.....
.....
9. HOW DID THE ACCIDENT OCCUR?.....
.....
.....
10. STATEMENT FROM WITNESS(ES) (ATTACH SEPARATE SHEET IF NECESSARY).....
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.....
11. NATURE OF INJURY (NOTE THAT FORMS A.B. & C. MUST ACCOMPANY THIS CLAIM FORM).....
.....
12. STEPS TAKEN TO PREVENT A RECCURENCE

THEREBY WARRANT THE TRUTH OF THE ABOVE STATEMENTS

DATE AND SIGNATURE OF MANAGER ON BEHALF OF EMPLOYER.....

NAME OF COMPANY.....