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TSEHAY INSURANCE S.C.

NOTIFICATION OF CLAIM
FOR ACCIDENTS AND DISEASES

Claim No.....

TO BE FILLED BY THE EMPLOYER

THIS FORM MUST BE COMPLETED AND RETURNED WITHIN SEVEN DAYS OF THE ACCIDENT OR DISEASE

Employer .....P.O.Box.....Tel No. .....

Address.....Town .....Sub City.....Woreda.....Kebele.....House No.....

Activity ..... policy No .....

Name of the injured person (in full) .....

Date of birth .....In the insured's Service from .....

Category of work..... Registration No .....

Date of the accident .....place of the accident .....

When was the Employer informed of the accident?.....

Brief description of the accident: _____

Daily wage Birr [ ] (Birr .....

Monthly Salary ..... (Birr .....

Witnesses On behalf of the Employer

.....

.....

.....

Date .....

Detachable slip for hospital; File No. .....

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TSEHAY INSURANCE S.C.

..... **BRANCH**

To ..... Hospital .....

Patient's name (in full) .....

Employer's Name .....Address.....

You are kindly requested to assist the bearer of this form and offer,him/her medical treatment and/or hospitalization if necessary. Your bill will be settled upon presentation .

N.B This form is valid only when it bears the employer's seal and signature and may only be used to authorize treatment and hospitalization in case of accident or occupational diseas:-

Please attach a copy of this slip with your bill

Date ..... 20 .....

.....
Employer's Signature

TO BE FILLED BY THE MEDICAL DOCTOR _____

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TSEHAY INSURANCE S.C.

..... **BRANCH**

Dr's Name .....

Hospital .....

Patient's name .....

Type of injury/disease .....

.....

Treatment Prescribed .....

.....

Sick Leave .....

(Please write in words)

Dose the Patient suffer from any other defect or disease? Please state if any

Date ..... 20 .....

.....
Signature

Logic Printing Press