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BUNNA INSURANCE S.C
Head Office ☎0111263146/0111262861 Fax 🖷0111119207 ✉ 81189
E-mail: bunnainsuceo S.C

Form No.: BIC/CLMT/0008/17

W/C Notification of Claim
For Accidents and Diseases

TO BE FILED BY THE EMPLOYER

This form must be completed and returned within seven days of the accident or disease

Employer ---------- Town ---------- Tel No ----------
Address P.OBox ---------- wereda ---------- Kebele----------
Activity ---------- Policy NO ----------
Name of the injured person (in full) ----------
Date of birth ----------
Category of work ---------- Registration NO. ----------
In the insured's service from ----------
Date of the accident ---------- place of the accident ----------
When was the Employer informed of the accident? ----------
-
Brief description of the accident ----------

Daily wage Birr ----------
Monthly Salary Birr ---------- ----------
The Employer

Witnesses

Bunna Insurance S.C Detachable Slip for Hospital File No ----------
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 Employers seal and signature, and may only be used to authorize treatment and/or hospitalization in case of accident or occupational disease.
Please attach a copy of this slip with your bill.
Date ----------
---------- Employer's Signature

Bunna insurance S.C To be filled by the Medical Doctor
Dr's Name ----------
Hospital ----------
Patient's Name ----------
Type of injury/disease ----------

Treatment prescribed ----------
(Please write in Words)
Does the patient suffer from any other defect or disease?
Date ---------- Signature ----------