Corporate Employee Accident Insurance Claim Form

Policy Number
Employee Name
Employee ID
Employee ID
Department
Designation
Date of Accident
Time of Accident
Location of Accident
Location of Accident
Describe the Accident
Nature of Injury
Treating Doctor/Hospital
Mittage News (a) (if any)
Witness Name(s) (if any)
Details of Claim
Amount Claimed
Date

Signature