

# Domestic Worker Accident Insurance Claim Form

## Policy Holder Details

Full Name

Policy Number

Address

Contact Number

## Domestic Worker Details

Full Name

Nationality

Identification Number

Contact Number

## Accident Details

Date of Accident

Time of Accident

Location of Accident

Description of Accident

Witness Name

Witness Contact

## Medical Attention

Was medical attention required?

Name of Hospital/Clinic

Details of Injuries

## Declaration

Name of Declarant

Date

Signature