中国太平
CHINA TAIPING

中國太平保險(澳門)股份有限公司
CHINA TAIPING INSURANCE (MACAU) CO., LTD.

澳門新口岸宋玉生廣場398號中航大廈10樓
Alameda Dr. Carlos D'Assumpção, No. 398,
Edifício CNAC, 10 Andar, Macau
Tel : (853) 2878 5578
Fax : (853) 2878 7218, 2878 6137, 2878 7216
Website: www.mo.cntaiping.com

EMPLOYEES' COMPENSATION CLAIM FORM

THE EMPLOYER

Name of Insured _____ Policy No. _____

Address _____ Tel. No. _____

THE INJURED PERSON

Name _____ Sex _____ Age _____ Occupation & Position When Employed _____

Address _____ Tel. No. _____

When did the Injured Person Enter Your Service _____ Was the Injured Person's Employment Casual or Regular _____

Is the Injured person in Your Direct Employ (If not give Name and Address of the Contractor)

_____

No. of Family Members, Marital Status of Injured Person

_____

THE ACCIDENT

The Accident Happened At _____ (Time) _____ (Date) Name of hospital Taken to in or out Patient, No. of Medical Registration _____

State Region Injury _____ State Nature of Injury and its Extent _____

Work Carried Out by the Injured when the Accident Happened _____

State Cause and Place of Accident _____

_____

The Witness of The Accident _____ The Relationship with the Injured _____

Address of the Witness _____

On What Date did the Injured Person Actually Ceases Work? _____ Upon What date did you receive notice of Accident _____

The Injured has Completely Recovered and Resumed his work on _____ (Date)

Was the Injured Person under the Influence of Drink or Drugs at the Time of Accident?

_____

Was the Machine, if used, Fenced or Guarded? _____

The Ordinary Health of the Injured _____

Had or Not Suffered From the following Diseases?
(Rheumatism, Convulsions, Diabets, Anemia, Hypertension, Heart Disease & Others)

_____

The Earnings of the Injured for the Past **THREE** Months are specified as following, for the Purpose of Compensation:

Name of the Injured _____ Date _____

Year, Month, Working Days / Hours	Wages	Value of Food, Fuel & Quarters & Any Other allowances etc.

Total _____

Grand Total (Wages & Allowances) _____

Annotation:
If the employee had worked for less than **THREE** Months, please state the date of the commence of the employment. If the injured person has been absent from work at any time during the period of employment, please state the period and the cause.

_____
Chop & Signature of the Employer

SPECIAL NOTES

1.
2. Please fill all the items of the claim form.
3. Please provide us the M/7 medical receipts or hospital medical receipts, medical report, recovery and sick leave certificates and X-ray report.
4. Please provide us the copies of the employment contract, sub-contractor, salary payment certificate and attendant record.
5. Please provide us copies of the name list of the employee register form, contribution name list of social security fund, ID card, etc.
6. The employer must inform the insurance company within 24 hours after the employer was notified the accident or occupational disease.

FOR THE COMPANY USE ONLY

Loss No.: _____ Premium: _____

Agent: _____ Type of Cover: _____

Period of Insurance: _____ The Forms collected on: _____

Total No. of Employees: _____ All the documents collected on: _____

Sum Insured: _____ Wages: _____

Remarks: _____

Address: Alameda Dr. Carlos D'Assumpção, No.398, Edifício CNAC, 10 Andar, Macau
Tel: (853)28785578 Fax: (853) 28786137, 28755604, 28787216, 28787218