

P.O.Box Tel
Claim No. _____

NOTIFICATION OF CLAIM
FOR ACCIDENTS AND OCCUPATIONAL DISEASES

TO BE FILLED BY THE EMPLOYER

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

Employer Town Tel. No
Address P.O.Box No Woreda No. Kebele No.
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 (Birr)
Monthly Salary (Birr)

Witnesses The Employer
.....
.....200.....

AWASH INSURANCE COMPANY s.c. Detachable slip for hospital file No.
P.O.Box 12637, Tel. 613630
ADDIS ABABA
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/or hospitalization in case of accident or occupational disease.
Please attach a copy of this slip with your bill.
Date 200
Employer's Signature

AWASH INSURANCE COMPANY s.c. TO BE FILLED BY THE PHYSICIAN NO. _____
P.O.Box 12637, Tel. 613630
ADDIS ABABA
Dr. 's Name
Hospital
Patient's name
Type of Injury/Disease
Treatment prescribed
Sick Leave (Please write in words the number of sick leave days)
Does the patient suffer from any other defect or disease?
Date200.....
Signature