NOTES

Note 1. If Section 3(v) is completed the following are the injuries deemed to result in permanent partial disablement under the First Schedule.

	INJURY	MINIMUM PERCENTAGE OF LOSS OF EARNING CAPACITY
(a)	Loss of arm above or at the elbow	70
(b)	Loss of arm below the elbow	60
(c)	Loss of leg above or at the knee	60
(d)	Loss of leg below the knee	50
(e)	Permanent total loss of hearing	50
(f)	Loss of thumb	25
(g)	Permanent total loss of hearing in one ear	20
(h)	Loss of sight of one eye	30
(i)	Loss of one phalanx thumb	10
(j)	Loss of index finger	10
(k)	Loss of any finger other than index finger	5
(l)	Loss of great toe	10
(m)	Loss of all toes on one foot	20

Note 2. The following are examples of broad types of occupation for which in your opinion, the claimant is deemed to be unfit.

(a) Involve long periods of standing
(b) Involve lifting of heavy weights
(c) Require acute unimpaired perspective vision
(d) Require unrestricted use of two hands
(e) Involve working below ground
(f) Involve working on ladders or scaffolding

Serial No.:

RHB INSURANCE BERHAD (Co. No. 38000-U)
LEVEL 12, WEST WING, THE ICON, NO.1, JALAN 1/68F, JALAN TUN RAZAK, 55000 KUALA LUMPUR
TEL: 03-2180 3000 / 2180 3200 FAX: 03-2161 6322 (Claims)

CLAIM FORM - ☐ WORKMEN'S COMPENSATION INSURANCE (WCA) ☐ FOREIGN WORKER COMPENSATION SCHEME (FWCS)

Policy No. : _____ Claim No. : _____

NOTIFICATION OF ACCIDENT FORM

Answering these question do not imply that the injured person is making, or will make a claim. The issuance of this form should not be construed as an admission of liability and is provided without prejudice to the Policy Terms and Conditions. All written communications received by the Employer concerning accidents to employees should be forwarded at once to the Company.

SECTION 1 - THE EMPLOYER

1. Name of Policyholder	
2. Address	Tel. No. :
3. Business / Occupation	

SECTION 2 - DETAILS OF ACCIDENT

4. Name	
5. Nationality	
6. Address	
7. Whether married or single	Age : Sex :
8. Stated the Nature of Occupation in which injured is employed	
9. Was the injured engaged in this occupation when the accident occurred?	
10. Is the injured in your direct employment? If not, give name and address of contractor	
11. When did the injured enter your service?	
12. Is the injured free from Physical Infirmity at the time of the accident? If not, give details	
13. If taken to Hospital, please state: (a) Name of Hospital (b) Whether still in Hospital (c) Whether in or outpatient treatment given (d) If discharged, date of discharge	 (a) (b) (c) (d)
14. If not taken to Hospital, please state whether being medically attended and if so, by whom	
15. State whether returned to work, if so, when?	
16. Are satisfied that the injured has met with a bona-fide accident of employment?	
17. Is the injured able to do partial work?	
18. What is the probable period of disablement?	Approximately :-

SECTION 3 - THE ACCIDENT

19. Please state	(a) Date of Accident	(a)
	(b) Place	(b)
	(c) Time	(c)
20. Please give full details of accident		
21. Has a report been made of to *It is compulsory to report to Labour Department it injury is fatal or results in permanent disability	(a) Labour Department :-	
	(b) SOCSO :-	
22. When date did you receive notice of accident and from whom?		
23. On what date did the injured cease work?		
24. Was anyone supervising the work the injured was engaged upon? If so, please state name of supervisor		
25. State details of injury		
26. If injury was caused by machinery or gearing		
(a) Was it fenced or guarded?	(a)	
(b) Was it being cleansed whilst in motion?	(b)	
(c) When was it last inspected by the machinery department? (Please enclose a copy of their report together with this form)	(c)	
27. Was the injured person under the influence of alcohol or drugs at time of accident?		
28. Was he guilty of misconduct or disobedience to otders or rules? If so, please give details.		
29. State through whose neglect it occurred.		

Please state the total of the last 6 months' wages of injured person (Please submit salary slips/wageroll report)	Bonuses Value of free Quaters and any other allowances etc over the same period	Total

Signature of Employer & Company's Chop _____ Dated _____

WCNC2/011199

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MEDICAL CERTIFICATE

FOREIGN WORKER COMPENSATION SCHEME (FWCS)

(for completion of form see notes on page 2)

Name : _____ Sex : _____

Occupation : _____ I/C No. : _____

I, the undersigned Medical Officer/ Practitioner, understand that the above claimant is making a claim for compensation under the Foreign Worker Compensation Scheme (FWCS) and having examined the said claimant, I hereby certift that :

(1) To the best of my belief the claimant is_____ years of age.

(2) The claimant is suffering from the following disease of disability :

_____

_____

(3) In my opinion the claimant has sustained the following degree of disablement as a result of the accident or occupation :

(i) Total Temporary Disablement which is estimated to last from _____ to _____

(ii) Partial Temporary Disablement which is estimated to last from _____ to _____

(iii) No Permanent Disablement from _____

(iv) Total Permanent Disablement from _____

(v) Partial Permanent Disablement as listed in the first Ordinance (See Note 1)

_____

(vi) Partial Permanent Disablement in the form of physical impairment described hereunder :

_____

_____

as result of which the claimant will not be able to accept employment in occupation which (See Note 2)

_____

_____

Name : _____ Signature : _____

Qualification : _____ Dated : _____