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ETHIOPIAN INSURANCE CORPORATION

BRANCH

P.O.Box _____ Tel. _____ Addis Ababa

NOTIFICATION OF CLAIM FOR ACCIDENTS AND DISEASES

Claim No _____

TO BE FILLED BY THE EMPLOYER

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

Employer _____ Town _____ Tel. _____

Address _____ P.O.Box _____ Higher _____ Kebele _____

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

_____ 20 _____

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Detachable slip for hospital;

File No

ETHIOPIAN INSURANCE CORPORATION

BRANCH

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 _____ 20 _____

Employer's Signature _____

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TO BE FILLED BY THE MEDICAL DOCTOR NO. _____

ETHIOPIAN INSURANCE CORPORATION
_____ BRANCH

Dr's Name _____

Hospital _____

Patient's name _____

Name of injury/disease _____

Treatment Prescribed _____

Sick Leave _____

(Please Write in Words)

Dose the patient suffer from any other defect or disease? Please state if any _____

Date _____ 20 _____

Signature _____