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ETHIOPIAN INSURANCE CORPORATION

_____ BRANCH

P.O.Box _____ Tel. _____ Addis Ababa

Claim No _____

NOTIFICATION OF CLAIM
FOR ACCIDENTS AND DISEASES

TO BE FILLED BY THE EMPLOYER

THIS FORM MUST BE COMPLEED 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 _____

የኢትዮጵያ መድን ድርጅት 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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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