

**MINISTRY OF SOCIAL SECURITY**  
**NATIONAL INSURANCE ACT.**  
**CLAIM FOR EMPLOYMENT INJURY DISABLEMENT (ACCIDENT CASE)**

**(IF YOU ARE CLAIMING DISABLEMENT BENEFIT FOR A PRESCRIBED DISEASED YOU SHOULD COMPLETE FORM EM 102 INSTEAD OF THIS FORM)**

N. I. No. 

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1. Full Name .....  
*State Mr./Miss/Mrs.*

2. Address .....  
.....

3. Date of Birth .....  
*Day Month Year*

4. Date of Accident .....

5. Name and address of Employer at the time of the accident.  
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.....  
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6. Occupation .....

7. Registration No .....

8. In what way are you disabled as a result of the accident?  
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.....  
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9. Are you at present incapable of work as a result of the accident? (Yes or No) .....

10. Are you fit to travel for medical examination? (Yes or No) .....

11. Have you attended a Hospital because of the accident?  
If "Yes", please give its name and address .....  
.....  
.....

Whether in-patient or out-patient period of treatment form .....

Were any X-Ray's taken? (Yes or No) .....

Do you agree to your hospital records being made available to the authorities deciding your claim?  
(Yes or No) .....

12. Were you awarded any benefits under the Workmen's Compensation Act in respect of the same accident?  
(Yes or No) .....

If "Yes" Give particulars .....  
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13. Address of Post Office at which you would like to receive payment or disablement benefit, if awarded?  
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I declared that the accident referred to at 4 overleaf arose out of and in the course of my employment and that all the particulars given on this form are true and to the best of my knowledge. I claim Employment Injury Disablement Benefit accordingly: -

.....  
*Date*

.....  
*Signature*

**NOTE**

If you did not report the accident to your employer, kindly do so now and explain to him that you are making a claim for Employment Injury Disablement Benefit.

If you are a patient in the hospital you may claim an increase in your pension (if an award is made).

.....  
*Signature*

.....  
*Date*