MINISTRY FOR FINANCE

OCCUPATIONAL PERSONAL ACCIDENT BENEFIT SCHEME

OCCUPATIONAL PERSONAL ACCIDENT BENEFIT SCHEME

FORM A
CLAIM NOTIFICATION FORM

Claim Reference: ________ / ________ / ________ (for office use)

PRELIMINARY GUIDANCE NOTES

(a) Once fully completed and signed, this form is to be forwarded within 14 days from the date of the accident to:
The Manager - Occupational Personal Accident Benefit Scheme c/o Ministry for Finance, 'Maison Demandols' , South Street, Valletta VLT1102

(b) Completion of this Form does not in any way imply an acceptance of liability by the Manager for the payment of benefits under the Scheme.

(c) If this space in this form is not sufficient to provide the full details in reply to any of the questions posed above, please append the additional Information on a separate sheet).

(d) ALL QUESTIONS MUST BE ANSWERED

CLAIM REFERENCE

1. Details about the Injured Employee

1.1	Name of the Employee	
1.2	ID Card Number	
1.3	Date of Birth	
1.4	Postal Address	
1.5	Home Telephone / Mobile Number	
1.6	Occupation / Grade:	
1.7	Government Department / Public Entity where employed	
1.8	Gross weekly / monthly salary	

2. Details about the Accident

2.1	Nature of the accident	
2.2	How it occurred	
2.3	What the Employee was doing at that time	
2.4	When did it occur (date & time)	
2.5	Place, including address, where it occurred	
2.6	Name/s and Address/es of witness/es present	

3. Details about the injury suffered

3.1	Describe as fully as possible the injuries sustained	
3.2	Date first received medical attention	
3.3	Name of the Medical attendant	
3.4	Address of the Medical Attendant	
3.5	Contact details of the Medical Attendant:	
	(e.g. telephone/mobile, email address etc)	
3.6	If hospitalised, where?	
3.7	Is a medical certificate(FORM B) being attached herewith?	
3.7	Will any claim be made under any insurance policy in respect of this accident	
3.8	If answer to 3.7 is' Yes' please give details of the insurance policy and insurer/s	

PLEASE ANSWER EITHER SECTION 4, OR SECTION 5 OR SECTION 6 (as applicable)

4. Declaration by the Employer

I, the undersigned, hereby declare that (i) Mr / Ms ______________________________ (name of the injured employee) is entitled to submit a claim under the Occupational Personal Accident Benefit Scheme for the Employees of the Public Sector. Furthermore I hereby confirm that all the answers provided in this form are true and correct.

Signature of the Employer	
Name of the Employer and Designation (in blocks)	
ID Card Number of the Employer	
Date	

5. Declaration by the Employee

I, the undersigned, hereby declare that I am entitled to submit a claim under the Occupational Personal Accident Benefit Scheme for the Employees of the Public Sector. Furthermore I hereby confirm that all the answers provided in this form are true and correct.

Signature of the Employee	
Name of the Employee and Designation (in blocks)	
ID Card Number of the Employee	
Date	

6. Declaration by the Employee's Representative

I, the undersigned, hereby declare that Mr / Ms ______________________________
name of the injured employee) is entitled to submit a claim under the Occupational Personal Accident Benefit Scheme for the Employees of the Public Sector. Furthermore I hereby confirm that all the answers provided in this form are true and correct.

Signature of the Representative	
Name of the Representative (in blocks)	
ID Card Number of the Representative	
Date	
Relationship of the Representative with the Employee	

7. List the documents attached to this Notification Form:

(i)	
(ii)	
(iii)	
(iv)	
(v)	

8. Any other pertinent information or comments: