AWASH INSURANCE COMPANY s.c.
P.O.BOX 12637, ADDIS ABABA
E-mail: aic@ethionet.et Website: www.awashinsurance.com

P.O.Box …… Tel …….
Claim No. _____

NOTIFICATION OF CLAIM

FOR ACCIDENTS AND OCCUPATIONAL DISEASES

TO BE FILLED BY THE EMPLOYER

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

Employer ……..…… Town …….……Tel. No ……...……..
Address …….……. P.O.Box No ……..…… Woreda No. …..……. Kebele No. ……..
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
…….
……. …….
……. ……..200……..

AWASH INSURANCE COMPANY s.c. Detachable slip for hospital file No. ……..…….
P.O.Box 12637, Tel. 613630
ADDIS ABABA
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 …….. 200 …….. ……
Employer's Signature

AWASH INSURANCE COMPANY s.c. TO BE FILLED BY THE PHYSICIAN NO. _____
P.O.Box 12637, Tel. 613630
ADDIS ABABA
Dr. 's Name ……..
Hospital ……
Patient's name ……..
Type of Injury/Disease …….
……
Treatment prescribed …….
…..……... (Please write in words the number of sick leave days)
Sick Leave …….
……
Does the patient suffer from any other defect or disease? .....
Date ……200 …….. ……
Signature