# FEDERAL REPUBLIC OF NIGERIA

# NIGERIA SOCIAL INSURANCE TRUST FUND (NSITF)

## (Employees' Compensation Act, 2010)

## Claim for Compensation

(Section 6(1) of the ECA)

| Case ID | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**Instructions**: This form must be completed by the Employer on behalf of the Employee. Use block letters or mark 'x' as appropriate. All fields are mandatory.

Indicate as appropriate: **Accident:** ☐ **Occupational Disease**: ☐ **Death**: ☐

**1.0 Employee:**

**Passport photograph**

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.1 | Surname | | | | | | | | | | | | | | | | |
| 1.2 | First name | | | | | | | | | | | | | | | | |
| 1.3 | Middle name | | | | | | | | | | | | | | | | |
| 1.4 | Staff ID.No. | | | | | | | | | | | | | | | | |

1.4 Marital Status: Married: ☐ Single: ☐ Divorced: ☐

1.5 Number of Spouse(s): ☐

1.6 Number of children: 0: ☐ 1: ☐ 2 or more: ☐

1.7 Age of Children (Indicate number of each category): 0 -12 years: ☐ 13 – 21 years: ☐

**2.0 Employer Name:**_____

_____

**2.1 Employer Address:**_____

**3.0 Registered Dependant:**

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.1 | Surname | | | | | | | | | | | | | | | | |
| 3.2 | First name | | | | | | | | | | | | | | | | |
| 3.3 | Middle name | | | | | | | | | | | | | | | | |
| 3.4 | Date of birth dd/mm/yyyy | | | | | | | | | | | | | | | | |

3.5 Gender: M: ☐ F: ☐

**4.0** Have you enjoyed any First Aid Treatment? Yes: ☐ No: ☐

**5.0** Date on which the injury/disease/death was reported to the Employer (dd/mm/yyyyy): ☐☐☐☐☐☐☐☐☐☐

**6.0** Date of first treatment (dd/mm/yyyy): ☐☐☐☐☐☐☐☐☐☐

**7.0 Health Provider (If more than one health provider, give details on a separate sheet):**

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name | | | | | | | | | | | | | | | | | | | | | | |
| Address | | | | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name of Specialist | | | | | | | | | | | | | | | | | | | | | |
| Practice number of Specialist | | | | | | | | | | | | | | | | | | | | | |

**8.0 DETAILS OF TREATMENT BILL**

| S/N | ACTION CARRIED OUT | DATE(dd/mm/yyyy) | AMOUNT CHARGED | REMARKS |
|---|---|---|---|---|
| 1 | Registration | | | |
| 2 | Consultation | | | |
| 3 | Admission | | | |
| 4 | Medical procedure | | | |
| 5 | Drugs/Pharmaceutical | | | |
| 6 | Laboratory Services | | | |
| 7 | Others…….. | | | |
| 8 | Others…….. | | | |
| 9 | Others…….. | | | |
| 10 | Others…….. | | | |
| 11 | Others…….. | | | |
| 12 | Others…….. | | | |
| | TOTAL | | | |

**9.0** Date injury/disease/death was sustained/diagnosed/occurred (dd/mm/yyyy): | | | | | | | | |

**10.0 Bank details of eligible person(s):**

| | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name of account | | | | | | | | | | | | | | | | | | | | | |
| Account number | | | | | | | | | | | | | | | | | | | | | |
| Sort Code | | | | | | | | | | | | | | | | | | | | | |
| Bank name | | | | | | | | | | | | | | | | | | | | | |

**10.1** Has the employee received any third-party compensation or expecting to receive any? Yes ☐ No ☐

**11.0** Compensation in accordance with the ECA, 2010 is hereby claimed in respect of the injury/Disease/Death described above.

I certify that the information in this form is to the best of my knowledge, correct.

_____ _____

Thumb print/Signature of employee/dependant Date

_____ _____

Employer's Stamp/Signature of authorized person Date

**Documents to attach:**

1. All receipts from treatment.
2. Detail of all bills which must be signed by each professional/Specialist with his practicing license number.
3. Recent Passport photograph.
4. Police report in case of road accident.
5. Affidavit deposed to by employee to confirm accident or occupational disease.