



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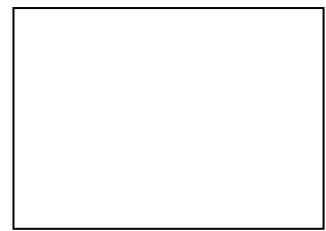
Instructions: This form must be completed by the Employer on behalf of the Employee. Use block letters or mark 'x' as appropriate. All fields are mandatory.

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/yyyy):

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):

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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.