FEDERAL REPUBLIC OF NIGERIA

NIGERIA SOCIAL INSURANCE TRUST FUND (NSITF)

(Employees' Compensation Act, 2010)

[Section 6(1)]

CLAIM FOR COMPENSATION

Case ID														

Instructions: *i. Use block letters or mark " √ "as appropriate..*
ii. All fields are mandatory.

Indicate as appropriate: **Injury:** ☐ **Occupational Disease:** ☐ **Death**: ☐ **Disability**: ☐

1.0. *EMPLOYER:

Name																												
Registration Number																												

2.0. *EMPLOYEE:

2.1.	Surname																		
2.2.	First name																		
2.3.	Middle name																		
2.4.	Staff ID No.																		
2.5	National ID No. (NIN)																		

Affix passport photo

2.6. *Gender: Male: ☐ Female: ☐

2.7. *Marital Status: Married: ☐ Single: ☐ Divorced: ☐

2.8. *Number of Spouse(s): ☐

2.9. *Number of children: 0: ☐ 1: ☐ 2 or More: ☐

2.10. *Age of Children (Indicate number of each category): 0 -21 years: ☐ 21 years & Above: ☐

3.0. *INJURY: *(Where applicable)*

3.1.	Date & Time *(24hour)* of Accident	D	D	/	M	M	/	Y	Y	Y	Y		&		H	H	:	M	M									
3.2.	Town/ Local Govt Area where Accident occurred																											
3.3.	State																											
3.4.	Date & Time Employee reported Accident	D	D	/	M	M	/	Y	Y	Y	Y		&		H	H	:	M	M									

3.5. Brief narration of how the Accident occurred:

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……

……

3.6. Period off duty: From D D M M Y Y Y Y to D D M M Y Y Y Y *(Attach supporting Document)*

4.0. *DISABILITY: *(Where applicable)*

4.1. Did any Disability occur from the injury? Yes ☐ No ☐

5.0. DEATH: *(Where applicable)*

5.1. Did the Employee die in the course of work? Yes ☐ No ☐

5.2. Brief narration of what led to Death:

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5.3. *Registered Dependant:

5.4.	Surname																	
5.5.	First name																	
5.6.	Middle name																	
5.7.	Date of Birth	D	D	/	M	M	/	Y	Y	Y	Y							
5.8.	National ID No. (NIN)																	

[Please attach list of dependant(s with their National Identification Number (NIN), if more than one.]

5.9. *Gender: M: ☐ F: ☐

6.0. *OCCUPATIONAL DISEASE: *(Where applicable in line with the 1st Schedule of the ECA,2010).*

6.1. Nature of Work: _____

6.2. Nature of Disease: _____

6.3. Year of first exposure: ☐☐☐☐

6.4. Date of Accident/Onset of Occupational Disease: D D M M Y Y Y Y

6.5. Date the disease was diagnosed: D D M M Y Y Y Y

6.6. For how long was he exposed? Year(s): ☐☐ Month(s): ☐☐ Day(s): ☐☐

6.7. Date Employee reported the Disease: D D M M Y Y Y Y

6.8. Date of First Consultation: D D M M Y Y Y Y

6.9. Describe how the accident happened or indicate the causative substance of Occupational Disease.

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6.10. Describe briefly any pre-existing defect/disease:

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6.11. State the positive aspects from the anamnesis and/or clinical examination supporting the diagnosis (Medical reports of all special investigations must be submitted)

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7.0 *TREATMENT BILL:

7.1.	Total Amount of treatment:	**₦**	**k**

Kindly attach details of treatment along with this form. (Also see overleaf)

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

9.0. *Bank details of eligible person(s) on Company letterhead paper. ☐

10.0. *DECLARATION:

10.1. Compensation in accordance with the ECA, 2010 is hereby claimed in respect of the Injury/Disease/Death/Disability described above.

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

_____ _____

Thumbprint/Signature of Employee/Dependant Date

_____ _____

Employer's Stamp/Signature of Authorized person Date

FOR OFFICIAL USE ONLY

Received and checked by:

_____ _____ _____

Name of Receiving officer (Branch Manager) *Staff No.* *Sign&Date*

Prerequisite documents to attach:

1. Detailed **Medical report** from treating physician with detailed Medical bill breakdown.
2. All **original Medical** receipts from treatment.
3. Recent **Passport photograph**(s) of employee.
4. **Police report** in case of Road traffic accident/Assault/Fatal workplace accident.
5. Evidence of accident/Photographic evidence.
6. Authorization from Employer & Employee granting our Medical team access to clinical notes of Employee. (for Claim Application **above ₦1, 500,000.00** [One Million, Five hundred thousand Naira]).
7. Employment letter and Staff ID of Employee.
8. Affidavit from Employee confirming accident/Occupational disease sworn from any court of competent jurisdiction.
9. In the case of *Loss-of-Productivity* attach payslip(s) and attestation of payment from employee.

*Compulsory fields must be filled