FEDERAL REPUBLIC OF NIGERIA

NIGERIA SOCIAL INSURANCE TRUST FUND (NSITF)

(Employees' Compensation Act, 2010)

REQUEST FOR RE-OPENING A CLAIM

N.B: *Part A: To be completed by Employer.*
Part B: By a Medical Doctor upon a relapse of an Occupational disease/ Injury.

Instructions: *i. Complete the Form in block letters or mark " √ " as appropriate.*
ii. All fields are mandatory.

***Part A:**

1.*Name of Employee:

Surname																	
First name																	
Middle name																	
Staff ID No.																	
National ID No. (NIN)																	

2.*Name of Employer:

Name																												
Registration Number																												

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

a) Date of Accident/Onset of Disease: D D M M Y Y Y Y

b) Date of Consultation: D D M M Y Y Y Y

c) Has permanent Disability been awarded by NSITF? Yes: ☐ No: ☐

d) Percentage of Disability (If known): ……

***PART B:**

In case of Death, Reason for re-opening; Appeal: ☐ others: ☐

If others, specify; ……

***PART C:**

1. State the specific diagnosis and the present condition of the employee:
……

2. List the special investigations performed to confirm (Part C. No.1) above. (Attach Reports):
……

3. Describe the relationship of the present condition to the original injury sustained/disease contracted. (If the only relationship is persistence of symptoms, provide dates of doctor's consultations, diagnosis, and treatment administered and attach sick leave records):
……
……

4. Detailed treatment plan, with date of hospital admission and proposed procedure(s); name of hospital and estimated costs. (Please, attach a separate page with this information, if the space provided is not enough).

……
……

5. How will the proposed treatment reduce the disablement the employee is suffering?
……
……

6. Other health team members who will be involved during the procedure/treatment:
……
……

*I certify that I have by Medical examination satisfied myself that the condition of the employee is the result of the accident/disease as described above.

Details of Medical Practitioner:

*Surname																			
*Other Names																			
*Practice Number																			
*Address																			
*Tel. Number																			
e-mail address																			

Doctor's Signature/Stamp: …… Date: ……

Signature of Employee: …….. Date: ……..

Employee's contact Number:……

Employer's Signature/Stamp: …….. Date: ……

FOR OFFICIAL USE ONLY

Received and checked by:

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