AlKoot INSURANCE & REINSURANCE الكوت للتأمين و إعادة التأمين	CLAIM FORM	AK-GI-FM-019 Rev.: 2 Date: 12/06/2025

WORKMEN'S COMPENSATION INSURANCE

Please note that this Claim Form is issued without prejudice to the terms and conditions of the policy and issuance of this form is not to be considered as an admission of liability. Kindly fill in all the blanks and give complete details of information asked. Please return this form, duly filled, sealed & signed, within 7 days, from the date of occurrence.

THE EMPLOYER/INSURED	
1.	Policy & Claim ID No.
2.	Name of Policyholder
3.	Business
4.	Address Phone Number :

Claim Details:

1.	Name	Age : Sex : Married / Single :
2.	Location/Permanent Address	
3.	State occupation/nature of work of the injured person	
4.	Was the injured person engaged in this occupation when the accident occurred? If not, state exactly the nature of the work he was doing at the time of accident	
5.	Is the injured person in your direct employment? If not give name and address of Contractor, under whom employed and nature of work entrusted to contractor	
6.	When did the injured person enter your service? (Date of Employment) and period in your service.	
7.	Has the injured person been medically examined or hospitalized? If so, please send copy of Medical report.	Medical Report Enclosed Yes ☐ No ☐

8.	Basic Wage Rate per month or per hour. State whether entitled to a paid holiday after every 6 days of work (State on the back of this form the earnings during the past 12 months)	
9.	Amount Claimed (Please attach supporting docuemnts)	

Other Details:

1.	Was the accident due to anyone's negligence? If yes, kindly confirm any claim pursued against them and submit supporting documents	Yes	☐	No	☐

2.	Whether injury / death is due to Road Accident, if yes, give full particulars and confirm any claim was/is/will be pursued with negligent party(ies). Please submit all supporting documents	Yes	☐	No	☐
3.	Whether any claim for the same claim was/is/will be pursued under Medical insurance also, if so, give full particulars.	Yes	☐	No	☐
4.	Details of Other Existing Insurances				

We/ I, the undersigned confirm that above given details are true & correct to the best of my/our knowledge

Place: _____ Signature of Policyholder: _____

Date: _____

Note: Please provide complete answers to all the above questions. Whether, Question is not applicable, please mention 'NA'. All communications should be forwarded to the following address. The complaint procedure is available in the below mentioned Website.

Claims Department,
Al Koot Insurance & Reinsurance Company;
P.J.S.C, P.O. Box 24563, Doha – Qatar, Telephone:
+974 4040 2999
Website www.alkoot.com.qa

Al Koot is a Private Joint Stock Company licensed by the Qatar Central bank