ብሔራዊ የኢትዮጲያ ኢንሹራንስ ኩባንያ (አ.ማ)
NATIONAL INSURANCE CO.OF ETHIOPIA (S.C)

---------- BRANCH
P.O.BOX ----------Tel ---------- Addis Ababa

Claim No ----------

NOTIFICATION OF CLAIM
FOR ACCIDENTS AND OCCUPATIONAL DISEASE

TO BEFILLED BY THE EMPLOYER
THIS FORM MUST BE COMPLETED AND RETURND WITHIN SEVEN DAYS OF THE ACCIDENT OR DI

Employer ---------- ----------Town ---------- Tel, No ----------
Address ---------- P.O. Box No ---------- Wereda ---------- Kebele ----------
Activity ---------- Policy No ----------
Name of the injured person (in full) ----------
Date of Birth ----------
Category of work ---------- Registration No ----------
In the Insured's Service from ----------
Date of the accident ---------- Place of the Accident ----------
When was the Employer informed of the accident? ----------
Brief description of the accident ----------

Dainly wage Birr ---------- (Birr ----------
Monthly salary ---------- (Birr ----------
Witnesses The Employer
---------- ----------

---------- ---------- 19 ----------

ብሔራዊ የኢትዮጲያ ኢንሹራንስ (አ.ማ) **Detachable Slip for hospital file No ----------**
NATIONAL INSURANCE COMPANY OF ETHIOPIA (S.C)
---------- BRANCH
To ---------- Hospital ----------
Patient's Name (in full) ----------
Employer's Name ---------- Address ----------
You are kindly requested to assist the bearer of this form and offer him/her medical treatment and/or Hospitalization if necessary. Your bill will be settled upon presentation.
N.B This form is valid only when it bears the Employer's seal and signature, and may only be used to authorize Treatment and/or hospitalization in case of accident or occupational disease.
Please attach a copy of this slip with your bill
Date ---------- 19 ---------- ----------
Employer's Signature

ብሔራዊ የኢትዮጲያ ኢንሹራንስ (አ.ማ) **TO BE FILLED BY THE MEDICAL DOCTOR**
NATIONAL INSURANCE COMPANY OF ETHIOPIA (S.C) **File No ----------**
---------- BRANCH
Dr's Name ----------
Hospital ----------
Patient's name ----------
Name of injury /disease ----------

Treatment prescribed ----------

(Please write in words)
Sick Leave ----------

Does the patient suffer from any other defect or disease
Date ----------19 ---------- ----------
Signature