

The Federated Employers'
Mutual Assurance Company Limited

(Reg. No. 1936/008971/06)

Head Office: Johannesburg

**COMPENSATION FOR OCCUPATIONAL
INJURIES AND DISEASES ACT, 1993
SECTION 39 - ANNEXURE 4**

EMPLOYER'S REPORT OF ACCIDENT

CLAIM NO:

The issue of this form is
not an admission of any
liability

DIRECTIONS FOR COMPLETION OF FORM BY EMPLOYER

This form must be completed:

1. Whenever an employee meets with an accident arising out of and in the course of his employment resulting in a personal injury for which medical treatment is required.
2. Whenever an employee reports any personal injury to his employer, if in making the report the employee alleges that such injury arose out of and in the course of his employment.

(IN CASES WHERE THE ACCIDENT HAS CAUSED DEATH OR IS LIKELY TO CAUSE DEATH, UNCONSCIOUSNESS OR AMPUTATION OR CASES WHERE THE INJURED EMPLOYEE IS PRESUMED UNABLE TO WORK FOR A PERIOD OF AT LEAST 14 DAYS, THE REGIONAL DIRECTOR OF MANPOWER MUST ALSO BE NOTIFIED BY TELEPHONE OR FAX WITHOUT DELAY.)

Step 1 Complete EMPLOYER'S REPORT In full

Step 2 Sign and date form where indicated.

Step 3 Hand "Part B" to the injured employee before he goes for initial medical treatment and instruct him to hand "Part B" to the medical practitioner or hospital concerned. In serious cases "Part B" must be forwarded to the medical practitioner or hospital without delay.

Step 4 Complete the rest of Part A, pages 1 and 2.

Step 5 Forward completed form together with a First Medical Report (if available) to:

**THAT REGIONAL OFFICE OF THE FEDERATED EMPLOYERS' MUTUAL ASSURANCE COMPANY LTD.
(FEM) WITH WHOM YOU HAVE INSURED YOUR LIABILITY IN TERMS OF THE COMPENSATION FOR
OCCUPATIONAL INJURIES AND DISEASES ACT, 1993.**

See Reverse Part B Page 1 for addresses.

NB:

- (1) Complete a separate form in respect of each injured employee.
- (2) This form must not be delayed in expectation of the employee resuming employment or awaiting medical reports.
- (3) An employer who fails to report any accident within 7 days of gaining knowledge of such accident on this form, shall be guilty of an offence in terms of the Compensation for Occupational Injuries and Diseases Act, 1993 and may be held liable for the full amount of compensation payable in respect of such accident.
- (4) An employer who fails to report any accidents that have caused death or are likely to cause death, unconsciousness or amputation or cases where the injured employee is presumed unable to work for a period of at least fourteen days to the Regional Director of Manpower by telephone or fax, shall be guilty of an offence in terms of the Occupational Health and Safety Act, 1993.
- (5) Use the appropriate form for the reporting of occupational diseases (1059/OOM).
- (6) If an injured employee should leave your employ, please keep a record of the address where he can be reached so that monies which might be payable to him by FEM, can be sent to him with your assistance.

NOTES FOR EMPLOYERS INFORMATION AND GUIDANCE

1. HOLIDAY FUND AND HOLIDAY BONUS CONTRIBUTIONS - CONTRIBUTIONS PAID BY EMPLOYERS IN THE BUILDING INDUSTRY TO THEIR EMPLOYEES IN RESPECT OF HOLIDAY FUNDS AND HOLIDAY BONUS, IRRESPECTIVE OF WHETHER SUCH CONTRIBUTIONS ARE PAID WEEKLY OR MONTHLY IN CASH OR PLACED TO THE CREDIT OF AN EMPLOYEE BY MEANS OF HOLIDAY STAMPS ARE REGARDED AS EARNINGS FOR THE PURPOSES OF THE ACT AND MUST BE REFLECTED IN SECTION 39 "PART A" PAGE 2.
2. ALLOWANCES - OVERTIME PAYMENTS OR OTHER SPECIAL REMUNERATION OF CONSTANT CHARACTER OR FOR WORK HABITUALLY PERFORMED MUST BE DECLARED IN SECTION 39 "PART A" PAGE 2.

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

(Section 39 - annexure 4)

(For official use only) Claim No

EMPLOYER'S REPORT OF ACCIDENT

Instructions: Complete the form in block letters and mark appropriate areas (X) Step 1: Complete only those sections in red. (For steps 2 to 6 see front cover)

DECLARATION BY EMPLOYER OR AUTHORISED PERSON

I/We hereby declare that the particulars shown in items 1 to 58 of this report, of an alleged injury on duty are to the best of my/our knowledge and belief true and accurate.

Signed on this ... day of ... in the year ...

Signature of Employer / Authorised person

EMPLOYER

- 1. Name of company registered with FEDERATED EMPLOYERS' MUTUAL ASSURANCE COMPANY LTD
2. FEM Policy Number - if known
3. Contact person
4. Street address
5. Postal Code
6. Postal address
7. Postal code
8. Tel. No
9. Fax No
10. Situation of business/site
11. Nature of business, trade or industry

EMPLOYEE

- 12. Is the injured employee the owner of or a partner in the business?
(a) Is the employee in your direct employ or that of a subcontractor?
13. Surname
14. First names
15. I.D. No
16. Date of Birth
17. Sex Male Female
18. Marital State Married Single
19. Citizen of
20. Personnel/Company No.
21. Occupation
22. Postal Address
23. Postal Code
24. Period in your employ (years/months)
25. Expected period of disablement (days) 0-13 days 14 & more

ACCIDENT

- 26. Date of accident
27. Time
28. Place of accident (Site)
29. District
30. Date employee reported accident
31. Time
32. What task was the employee performing at the time of the accident?
33. Period of experience in task performed (years/months)
34. Was his action at the time of the accident in connection with your trade or business? Yes No
35. Short description of how the accident occurred. (ALSO mark the applicable items on "PART A" Page 3 and use "PART A" Page 3 for a full description).
36. Was the accident a traffic accident on a public road? Yes No
37. Nature of injury sustained. (e.g. index finger of right hand crushed)
Mark any of the following if applicable: Fatal Amputation Unconsciousness
38. Are you satisfied that the employee was injured in the manner alleged by him? Yes No If no give reasons

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I/We hereby declare that the particulars shown in items 1 to 58 of this report, of an alleged injury on duty are to the best of my/our knowledge and belief true and accurate.

Signed on this ... day of ... in the year ...

Signature of Employer / Authorised person

EMPLOYER

1. Name of company registered with FEDERATED EMPLOYERS' MUTUAL ASSURANCE COMPANY LTD
2. FEM Policy Number - if known
3. Contact person
4. Street address
5. Postal Code
6. Postal address
7. Postal code
8. Tel. No
9. Fax No
10. Situation of business/site
11. Nature of business, trade or industry

EMPLOYEE

12. Is the injured employee the owner of or a partner in the business?
(a) Is the employee in your direct employ or that of a subcontractor?
13. Surname
14. First names
15. I.D. No
16. Date of Birth
17. Sex Male Female
18. Marital State Married Single
19. Citizen of
Work Permit No. if non S.A. Citizen
20. Personnel/Company No.
21. Occupation
22. Postal Address
23. Postal Code
24. Period in your employ (years/months)
25. Expected period of disablement (days) 0-13 days 14 & more

ACCIDENT

26. Date of accident
27. Time
28. Place of accident (Site)
29. District
30. Date employee reported accident
31. Time
32. What task was the employee performing at the time of the accident?
33. Period of experience in task performed (years/months)
34. Was his action at the time of the accident in connection with your trade or business? Yes No
35. Short description of how the accident occurred. (ALSO mark the applicable items on "PART A" Page 3 and use "PART A" Page 3 for a full description).
(Refer to the machine process involved and whether the injured person fell or was struck and all the factors contributing to the accident)
36. Was the accident a traffic accident on a public road? Yes No
37. Nature of injury sustained. (e.g. index finger of right hand crushed)
Mark any of the following if applicable: Fatal Amputation Unconsciousness
38. Are you satisfied that the employee was injured in the manner alleged by him? Yes No If no give reasons

DIRECTIONS TO MEDICAL PRACTITIONER / HOSPITAL

- 1 Note that if liability is not accepted by the Employee's Compensation Commissioner medical expenses cannot be paid by the Federated Employers' Mutual Assurance Company Limited.
- 2 The first medical report must be completed in duplicate and care must be taken to ensure that the full names of the employee and the employer as shown in this form, appear thereon. The original must be forwarded to that regional office of the Federated Employers' Mutual Assurance Company Limited with which the employer has insured his Compensation for Occupational Injuries and Diseases Act liability as soon as possible. The duplicate must be retained by the medical practitioner or hospital together with this form.

REGIONAL OFFICES OF THE FEDERATED EMPLOYERS' MUTUAL ASSURANCE COMPANY LIMITED

HEAD OFFICE

Private Bag 87109, Houghton, 2041
Building No 2, 1st Floor
101 Central Street, Houghton,
Johannesburg 2198
Telephone: (011) 359-4300
Facsimile: (011) 359-4302

Cape Town

AGM Operations
R Saunders

Claims Manager - Cape
C Lopes

P O Box 2555, Cape Town, 8000
80 Strand Street, 8th floor, Cape Town, 8001
Telephone: (021) 418-3210
Facsimile: (021) 425-1544

Johannesburg

Area Manager - Inland
D Joss

Claims Manager - Johannesburg
K Mckop

Private Bag 87109, Houghton, 2041
Building No 2, 1st Floor
101 Central Street, Houghton,
Johannesburg 2198
Telephone: (011) 359-4300
Facsimile: (011) 359-4336

Durban

Branch Manager - Durban
M Vernon

P O Box 429, Durban, 4000
16th floor, Mercury House
320 Smith Street, Durban, 4000
Telephone: (031) 304-8958/9
Facsimile: (031) 304-3158

Pretoria

Branch Manager - Pretoria
C van Biljon

P O Box 6812, Pretoria, 0001
7th floor, Shorburg Building
429 Church Street, Pretoria, 0002
Telephone: (012) 322-7857/8/9
Facsimile: (012) 320-4698