# TWENTY-FOURTH SCHEDULE

[Section 86]

# NOTIFICATION OF OCCUPATIONAL DISEASE BY INSURER

Name ......................................................................................................................………………..

Address ..................................................................................................................…………….....

Business Registration no. ..............................................................................................................

Telephone no. ....................................... Mobile no. .......................................

Details of contact person

Name ......................................................................................................................………………..

Designation ...................................................................................................................................

Address ..................................................................................................................…………….....

National Identity Card no. ..............................................................................................................

Telephone no. ....................................... Mobile no. .................................................

Email address ................................................. Fax no. ......................................................

Name of the employee suffering from disease/deceased\* ...........................................................

National Identity Card no. ..............................................................................................................

Contact details of employee suffering from disease

(1) Office

Telephone no. ................................................ Mobile no. .................................................

Email address ................................................. Fax no. ......................................................

(2) Residence

Telephone no. ....................................... Mobile no. .................................................

Contact details of next of kin of deceased

(1) Office

Telephone no. ................................................ Mobile no. .................................................

Email address ................................................. Fax no. ......................................................

(2) Residence

Telephone no. ....................................... Mobile no. .................................................

Particulars of occupational disease (please attach medical certificate) ...........................................

Name of employer ...........................................................................................……………………….......

Address ........................................................................................................................................

Contact details

(1) Office

Telephone no. ................................................ Mobile no. .................................................

Email address ................................................. Fax no. ......................................................

(2) Residence

Telephone no. ....................................... Mobile no. .................................................

Nature of business ………………………...........................................………………………………..

Any further particulars ………….…………..........................................………….……………….......

I certify that to the best of my knowledge that the information given above is correct.

………………………….. ……………………….

Name of officer Signature

………………………….. …………………………..

Date Office stamp