The Federated Employers Mutual Assurance Company (Rf) Pty) (Ltd)
Reg. No. 1936/008971/07

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, AS AMENDED
Section 6(A) – Annexure 13

EMPLOYERS REPORT OF AN ACCIDENT

The issue of this form is not an Admission of liability

DIRECTIONS FOR COMPLETION OF THIS FORM BY EMPLOYER

1. Whenever an employee meets an accident arising out of and in the course of his/her employment resulting in a personal injury for which medical treatment is required or death results.

2. Whenever an employee reports any personal injury to his/her employer, if in making the report the employee alleges that such injury arose out of and in the course of his/her 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 PROVINCIAL EXECUTIVE MANAGER OF EMPLOYMENT AND LABOUR MUST ALSO BE NOTIFIED BY TELEPHONE OR BY E-MAIL. An employer who fails to report this by telephone shall be guilty of an offence in terms of the Occupational Health and Safety Act,1993.

3. With effect from 1 January 2004, as per regulations stipulated in the various Government Gazettes a certified copy of the employee's Identity Document / Passport / Working Permit and together with a Payslip / Proof of employment / Certificate of service as at the time of accident must accompany each employer's report of accident. This instruction from the Compensation Commissioner's Office has become necessary to eliminate fraudulent claims.

Step 1 Complete EMPLOYER'S REPORT OF ACCIDENT in full (as detailed and accurate as possible) and SUBMIT to FEM WITHING 7 DAYS without delay.

Step 2 The employer or designated person who completed the form must print his / her name, state their designation, sign and date the form.

Step 3 **Documents to accompany Employer's Report (pages 1 to 3) are:**
(a) Certified copy of the employees ID or Passport
(b) Proof of employee's employment

Step 4 Hand copy of the abovementioned documents together with "PART B" of this form, to the injured employee before he / she goes for initial medical treatment and instruct him / her to hand copies to the medical practitioner or hospital concerned. In serious cases a Copy of Employer's Report "PART B" must be forwarded to the medical practitioner or hospital without delay.

Step 5 Forward completed PART A together with a First Medical Report (if available) to:
THE FEDERATED EMPLOYERS' MUTUAL ASSURANCE COMPANY (RF) (PTY) LTD (FEM) WITH WHOM YOU HAVE INSURED YOUR LIABILITY IN TERMS OF THE COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT,1993 AS AMENDED to (FEM-registry@fema.co.za)

See last page for addresses

N.B.
1) Complete a separate form in respect of each injured employee.
2) This from 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, shall be guilty of an offence in terms of the Compensation for Occupational Injuries And Diseases Act,1993 As Amended and may be held liable for the full amount of compensation payable in respect of such accident. (Section 38, 39 and 43 has reference to an IOD and Section 65 and 68 in case of OD claim. (Extract-Government-gazette No. 42021-9 November 2018)
4) Use the appropriate Employer's Report Of An Occupational Disease for reporting occupational diseases.
5) If an injured employee should leave your employ, please keep a record of the contact details and address where he/she can be reached so that monies which might be payable to him/her by FEM, can be sent to him/her with your assistance.
6) Minor injuries where no medical attention was required should not be reported, however a record should be kept of such injuries, preferable by the First Aider of Occupational Health and Safety Officer.
7) FEM is obliged to report any injured employees who are not in possession of a valid certified ID or work permit (including foreigners) issued by Department of Home Affairs to the Department of Employment and Labour.

8) NB – Any additional details in respect of injuries can be completed as free text.

DIRECTIONS TO MEDICAL PROVIDERS

1. ONLY FEM shall decide whether liability in respect of an accident should be accepted in terms of the provisions of the ACT, in line with FEM's licence.
2. If Liability is not accepted by FEM, medical expenses CANNOT be paid in terms of COIDA.
3. The FIRST MEDICAL REPORT must be completed in DUPLICATE and care must be taken to ensure that the full names of both the employer, the employee and the employee's ID number appears on the form. The original form must be sent to FEM and duplicate must be kept by the medical provider together with a copy of the employer's report of accident. The Medical Service Providers must upload their account onto FEM's IMS System and attach the supporting documents. For example, First Medical Report, Xray Report etc,

EMPLOYERS REPORT OF AN ACCIDENT

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, AS AMENDED

Section 6(A) – Annexure 13

The Federated Employers Mutual Assurance Company (Rf) Pty) (Ltd)

Instructions to complete the form in block letters and mark appropriate areas (X)

EMPLOYER

1) Name of the company registered with the FEDERATED EMPLOYES' MUTUAL ASSURANCE COMPANY (RF) (PTY) LTD (FEM).

....

2) FEM Policy Number .... 3) WCC Reference number – If known ....

4) Contact person .... 5) Designation ....

6) Street Address .... 7) Postal code ....

8) Postal Address .... 9) Postal code ....

10) Tel. No. .... 11) E-mail Address ....

12) Situation of business/site .... 13) Nature of business, trade, or industry ....

EMPLOYEE (CERTIFIED COPY OF IDENTITY/PASSPORT AND PROOF OF EMPLOYMENT TO BE ATTACHED)

14 (a) Is the injured employee a

Working Director	Working member of a CC	Owner	Partner in the business	Not applicable

14 (b) Is the employee in your direct employee of that of a sub-contractor..

Directly employed	Sub-contractor

15) Surname .... 16) First names ....

17) ID / Passport / Work Permit Number 18) Date of birth | | | | | | | | | 19) Sex | Male | Female | Other |

(If not a citizen of South Africa, please attach a copy of the employees work permit)

20) Personnel Staff No. .... 21) Occupation .... 22) Marital Status | Married | Single | Other |

23) Street Address .... 24) Postal code ....

25) E-Mail Address .... 26) **CELL no**...

27) Period in your employment

M	M	Y	Y	Y	Y

28) Expected Period of Disablement (days)

0 – 13 days	14 days & more

29) NEXT OF KIN, FAMILY OR FRIENDS CONTACT DETAILS

CONTACT 1

....

....

NAME, SURNAME and CELL NUMBER

CONTACT 2

....

....

ACCIDENT

30) Date of accident | | | | | | | | | 31) Time of Accident | |

32) Date on which the employee reported the accident | | | | | | | | | 33) Time Reported | |

(If NOT on the same date of the accident, then state reasons as free text provided) ....

34) Did the accident occur on the companies' premises or designated site? .... 35) District .... 36) Province ....

37) What task was the employee performing when the accident occurred ....

38) Period of experience in that specific task performed at the time of the accident (years / months) | | | | | | |

39) Was his/her action at the time of the accident in connection with your trade or business?.. YES NO

(If "NO" state reasons on the free text provided) ....

40) Short description of how the accident occurred. We need the **work-related agent** that caused the accident. (Refer to the machine / process involved and whether the injured employee fell or was struck and all the factors contributing to the accident e.g., busy painting slipped off ladder. Use free text provided for more details.

....

....

....

ACCIDENT continues

41 a) What part of the body was injured (e.g., index finger of right hand crushed) ....

b) Mark any of the following where applicable.

Fatal	Amputation	Unconsciousness

42) Are you satisfied that the employee was injured in the manner alleged by him/her (If not, give reasons? .... YES NO

(If "NO" state reasons on the free text provided / attach your own statements

43) Total number of employees injured in the same accident?.......... 44) Was it a traffic accident on a public Road? .... YES NO

45) If the S.A. Police investigated the accident, state the name of the police station and case number ....

46) If other motor vehicles were involved, furnish registration number(s) ....

FURTHER PARTICULARS

47) Should the employee, to your knowledge have any physical defect, suffer from any serious disease prior to the accident or previously have received compensation for permanent disablement, give full particulars ....

....

48) Was first aid given in this case?.......... **YES** **NO**

49) If a medical practitioner treated the employee, state the name of the practitioner (if known, also state contact details and practice numbers)

....

50) If the employee received treatment at a hospital, state the name of the hospital ....

51) Was the accident caused by the employee's: .... (a) Deliberate non-compliance with directions ? .... **YES** **NO**

(b) Reckless disregard of the terms of any law or statutory regulation designed to ensure the health and safety of employees .... **YES** **NO**

(c) Action while under the influence of liquor or drugs?.......... **YES** **NO**

NB: (If any reply is in the affirmative, the employee **and** the employer must furnish explanatory statements which must then be attached hereto.

52) Name, address nd contact number of anybody:

(a) Who witnessed the accident ?..........

(b) Who was aware of the accident at the time ?..........

CONTINUATION OF POINT 42 ON THE PREVIOUS PAGE 2.

Contributing factors/causes applicable. (Mark the applicable item/s at A and B)

A)			B)			C)		
	Defective Plant			Railway			Explosions	
	Defective machine			Building work			Rotating machine	
	Unfavourable conditions at work			Electricity			Press/Rollers	
	Fault of employer			Chemicals			Woodworking machine	
	Fault of injured employee			Poisoning			Lifting machine	
	Fault of supervisor			Burns			Hand tool	

Other machinery (Specify) ....

Any other contributing factors not mentioned above (Specify) ....

....

....

DECLARTION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 1 to 56 of this report of an alleged injury on duty are to the best of my knowledge and belief true and accurate.

SIGNATURE ....

PRINT NAME .... POSITION / DESIGNATION..........

SIGNED ON THIS .... DAY OF .... IN THIS YEAR ....

ADDITIONAL DETAILS OR COMMENTS REGARDING THE ACCIDENT – FREE TEXT

The rest of this page may be used for any additional details

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DECLARTION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 1 to 56 of this report of an alleged injury on duty are to the best of my knowledge and belief true and accurate.

SIGNATURE ....

PRINT NAME .... **POSITION / DESIGNATION**...

SIGNED ON THIS .... **DAY OF** .... **IN THIS YEAR** ....

REGIONAL OFFICES OF THE FEDERATED EMPLOYERS MUTUAL ASSURANCE COMPANY (RF) (PTY) LTD

National Claims Manager	Jacqueline Mahlangu (011 359 4319)
Postal Address	Private Bag 87109, Houghton, 2041.
Physical Address	114 Oxford Road, Houghton Estate, Johannesburg. 2198
Telephone Number	011 359 4300
EMAIL ADDRESS	FEM-Registry@fema.co.za Enquiries@fema.co.za Femcomplaints@fema.co.za
WEBSITE	WWW.FEMA.CO.ZA https://roe.fem.co.za/

	JOHANNESBURG	CAPE TOWN	DURBAN
Regional Branch Manager:	Lydia Mentoor (011 359 4307)	Zuneid Sayed (021 443 2220)	Ivan Naidoo (031 277 0667)
Postal Address:	Private Bag 87109, Houghton, 2041.	P O Box 2555, Cape Town, 8000	P O Box 1157, Umhlanga Rocks, 4320
Physical Address:	114 Oxford Road, Houghton Estate, Johannesburg, 2198.	The Towers, 12th Floor 2, Heerengracht, Cnr Hertzog & Boulevard Foreshore, Cape Town, 8001.	1st Floor Rewards Building, 2 Ncondo Place, Umhlanga Ridge, 4320.
Telephone Number:	011 359 4399	021 443 2200	031 277 0660

THE PROVINCIAL EXECUTIVE MANAGER OF EMPLOYMENT AND LABOUR

Name	Department of Employment and Labour
Postal Address	P O Box 4560, Johannesburg 2000
Physical Address	77 de Korte Street, Braamfontein, Johannesburg, 2001
Telephone Number	011 853 0300
EMAIL ADDRESS	Gauteng PO@labour.gov.za,gp.customercare@labour.gov.za
WEBSITE	http://www.labour.gov.za
Call Centre	086 010 5350
Fax	011 853 0170

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, AS AMENDED
Section 6(A) – Annexure 13

EARNINGS (COMPULSORY TO COMPLETE) can be submitted once the employee has received medical attention

EMPLOYER .... **DATE OF ACCIDENT** ....

EMPLOYEE .... **EMPLOYEE'S I.D. NO.** ....

NOTES FOR EMPLOYERS' INFORMATION AND GUIDANCE ON EARNINGS - TO BE COMPLETED BY THE HR DEPARTMENT

1. HOLIDAY FUND / BONUS CONTRIBUTIONS – contributions paid by employers in the building industry to their employees in respect of holiday funds / bonus, irrespective of whether such contributions are paid weekly/monthly in cash or placed to the credit of an employee by means of holiday stamps are regarded as earnings for the purpose of the act and must be disclosed below.
2. ALLOWANCES – overtime payments or other special remuneration of constant / regular nature including incentive bonuses for work habitually performed must be disclosed below.

If the injured is the Director of a Company or Members of a Close Corporation the Earnings / Drawings must be disclosed.

53) Earnings of an employee at the time of an accident	**R / Week**	**R / Fortnight**	**R / Month**
a) **Basic Wage**	....	....	....
b) Allowance of a recurrent nature:			
• Bonuses of any kind, including incentive bonuses and annual bonuses. (Specify nature)	....	....	....
• Commission earned, even though the amount may vary from month to month. (Specify nature)	....	....	....
• Overtime of a regular nature	....	....	....
• Other allowances of a regular nature (specify)	....	....	....
c) The cash value of food and quarters			
• Free food	....	....	....
• Free quarters........................	....	....	....
d) Cash value of fringe benefits such as a company car, free accommodation, or at a reduced rate, etc. (Specify nature)	....	....	....
e) Travel and other allowances paid regularly, as part of the package. (Specify Nature)	....	....	....
f) Holiday Fund .... **Cash** **Stamp Code**	....	....	....
Remember to attach the BIBC Stamp sheet for applicable year			

54)

In terms of section 47 (3) of the Act, the employer is liable for the payment of compensation (i.e., 75% of the wages) for the first three months from the date of accident or until the employee resumes work (refundable by FEM)

a) If you have already paid cash to the employee, state the amount R ....

b) For what period were such payments made ? **FROM** | D | D | M | M | Y | Y | Y | Y | **TO** | D | D | M | M | Y | Y | Y | Y |

55) Number of days / hours per week worked by the employee ....

56) Date on which the employee ceased work due to the accident .... | D | D | M | M | Y | Y | Y | Y | 57) Time ....

58) Did the employee complete his shift on the day of the accident .... **YES** **NO**

Time shift starts: .... Time shift supposed to end: ....

59) Date on which the employee resumed work after the accident .... | D | D | M | M | Y | Y | Y | Y | 60) Time ....

If the employee has not yet resumed work, a Resumption Report must be submitted as soon as he/she resumes duty ....

Please confirm whether you intend to continue to pay the employee's salary beyond three months ....

DECLARTION BY EMPLOYER OR AUTHORISED PERSON

I hereby declare that the particulars, shown in items 53 to 60 of this report of an alleged injury on duty are to the best of my knowledge and belief true and accurate.

SIGNATURE ....

PRINT NAME .... **POSITION / DESIGNATION**..

SIGNED ON THIS .... **DAY OF** .... **IN THIS YEAR** ....