

EMPLOYER'S LIABILITY CLAIM FORM

POLICY NO.		CLAIM NO.	
INSURED DETAILS			
Insured's name:			
Insured's address:			
Daytime telephone:	Mobile telephone:	Email:	
Nature of Business:			
Date of accident:		Place of accident:	
Time of accident:			
When the accident was first reported and by whom			
INJURED PERSON			
Name of injured person			
Address of injured person			
Date of Birth		Marital status	
Sex		No. of Dependents	
What is his or her present position?			
Give a detailed description of this position.			
Is he/she a temporary or permanent employee?			
Is he/she a sub-contracted employee?			
If yes, state the name and address of the sub-contractor.			
ACCIDENT DETAILS			
1. Give a detailed description of how the accident occurred. <i>(If space provided is insufficient, please attach a written report)</i>		
2. If the accident was due to any defect in machinery or scaffolding or other equipment, state nature of defect. (Defective parts should be retained)		
3. Was he/she performing a duty for which he is employed?		
4. Was he disobeying any rule or order?		5. Who was in charge?	
6. Was the accident due to another person's negligence? If yes, give particulars.			



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7. Nature of injury.	
8. Did he/she cease work immediately?	
9. If no, when did he/she cease work? Give date and time.	
10. Was First Aid treatment administered? If yes, by whom at what location?	
11. If no, was he/she taken to a medical facility?	
12. What is the name of the medical facility	
13. If taken to a hospital, state whether he/she was admitted as in-patient or out-patient.	
14. Name and addresses of witnesses 1. Witness 2. Witness 3. Witness

WAGES

Statement of the injured person's earnings from me/us during the twelve months preceding the accident, or during the period of his/her employment, if shorter. If he/she has been absent from work for any part of the period please enter "nil" in the wages column and state reason.

#	Week ended Month/day	#	Week ended Month/day

State whether there are any other earnings or perquisites such as board and/or lodging, rent, allowances in kind, etc.

Full description	
Estimate value yearly	

OTHER INFORMATION

Is there any other form of insurance covering accidents to your employees?	
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I/We declare that the above written statements above is true and correct to the best of my/our knowledge.

Signature:

Date: