GENERAL INSURANCE COMPANY LIMITED

58 HALF WAY TREE ROAD, KINGSTON 10.

EMPLOYERS' LIABILITY CLAIM

POLICY NO. AND RENEWAL DATE	PREMIUM PAID TO	CLAIM NO.
ISSUING COMPANY	BRANCH	CHECKED BY
Have you any other policy in force covering your liability as an employer? .... YES or NO	If so, please give name of Company and Policy No.	

1 EMPLOYER'S NAME TRADE OR BUSINESS	ADDRESS TELEPHONE NO.
2 EMPLOYEE'S NAME AGE OCCUPATION	ADDRESS INDICATE PHYSICAL DEFECTS (IF ANY) APART FROM PRESENT ACCIDENT

STATE WHETHER MARRIED SINGLE WIDOW WIDOWER (Delete as necessary)	STATE NO. OF CHILDREN	DATE OF COMMENCEMENT OF EMPLOYMENT
IF AN APPRENTICE, WHEN DOES APPRENICESHIP FINISH?	WAS THE INJURED PERSON IN YOUR DIRECT EMPLOYMENT AND PAY?	IF NOT, WAS HE/SHE IN THE EMPLOY OF A CONTRACTOR TO YOU?

IMPORTANT NOTE
If any claim is received please advise us Immediately and forward the letter unanswered.

3 Statement of weekly wages/salary of injured employee for the past twelve months

Income Tax code no	

Week commencing .... to week ending ....

WEEK	GROSS AMOUNT	NET AMOUNT i.e. after deduction of Income Tax and N.I. contributions	WEEK	GROSS AMOUNT	NET AMOUNT i.e. after deduction of Income Tax and N.I. contributions	WEEK	GROSS AMOUNT	NET AMOUNT i.e. after deduction of Income Tax and N.I contributions
1			B/F			B/F		
2			19			36		
3			20			37		
4			21			38		
5			22			39		
6			23			40		
7			24			41		
8			25			42		
9			26			43		
10			27			44		
11			28			45		
12			29			46		
13			30			47		
14			31			48		
15			32			49		
16			33			50		
17			34			51		
18			35			52		
C/F			C/F			TOTAL		

for .... Weeks

I/We hereby declare the above wages/salary particulars to be true in every respect.

SIGNATURE OF EMPLOYER……………………………………………………………DATE………………………

4 DESCRIBE THE NATURE OF THE INJURIES

IF REMOVED TO HOSPITAL OR OTHERWISE MEDICALLY EXAMINED PLEASE STATE NAME AND ADDRESS OF DOCTOR OR HOSPITAL

STATE DATE ON WHICH EMPLOYEE

(a) Left off work

(b) Returned to any part of former work

(c) If not yet returned, state date employee is expected to return (if known)

(d) If accident terminated fatally give DATE OF DEATH

5 DATE OF ACCIDENT: TIME: A.M./P.M.

WHEN WAS THE ACCIDENT FIRST REPORTED TO YOU OR YOUR REPRESENTATIVE

IF NOT REOPORTED TO YOU, TO WHOM WAS THE ACCIDENT REPORTED?

HAS THE OCCURRENCE BEEN ENTERED IN YOUR ACCIDENT BOOK?

WHERE DID THE ACCIDENT OCCUR?

NATURE OF WORK BEING PERFORMED AT TIME OF ACCIDENT

IF THE ACCIDENT IS CONNECTED WITH MACHINERY

(a) WAS IT PROPERLY GUARDED? (b) WAS THE GUARD IN USE?

(c) HAS H.M. FACTORY INSPECTOR EXAMINED SINCE THE ACCIDENT?

WAS ACCIDENT DUE TO NEGLIGENCE?

IF SO, GIVE NAME, ADDRESS AND OCCUPATION OF THE PERSON WHOSE NEGLIGENCE CAUSED THE ACCIDENT

WHAT NEGLIGENCE IS ALLEGED?

IS THERE ANY SUSPICION THAT THE INJURED EMPLOYEE WAS

(a) UNDER THE INFLUENCE OF DRINK

(b) VIOLATING ANY OF THE RULES OF THE ESTABLISHMENT?

NAME AND POSITION OF OVERSEER OR PERSON
IN AUTHORITY OVER THE INJURED EMPLOYEE

NAME AND ADDRESS OF WITNESS

DESCRIPTION OF THE ACCIDENT

I/We certify that the foregoing statement is a true account to the best of my/our knowledge and belief.

SIGNATURE OF EMPLOYER……………………………………………………………DATE……………………………………

NOTE: **(a) The designation of the person signing must be given.**

(b) Signature must also be given below statement of wages/salary on previous page.

If injuries are likely to prove fatal contact Head Office at once

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EMPLOYERS' LIABILITY CLAIM

In any correspondence concerned
with this intimation please
quote the following:

CLAIM NO.

DATE OF ISSUE
OF REPORT FORM

THE FORM SHOULD BE RETURNED
WITHIN TWO DAYS TO ENSURE
PROMPT ATTENTION.

Please complete this form, answering all questions relevant to the accident, and return as quickly as possible.

This report is required for the information of our Solicitor only to enable him to prosecute or defend proceedings in the event of litigation arising out of matters referred to in the report.

You are reminded that we cannot hold ourselves responsible for any payments made to injured employees without our authority.

If an accident has in any way been caused by machinery, no alteration in such machinery should be made without first obtaining our authority.

IMPORTANT

If any claim is received please advise us immediately and Forward the letter unanswered.

FORM ISSUED BY

OFFICE OF ISSUE: