JAMAICA INTERNATIONAL INSURANCE COMPANY LIMITED

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EMPLOYERS LIABILITY

Claim No. _____

Policy No. _____ Date of Policy _____ Date of Last Renewal _____

POLICYHOLDER-

1. Name (in full) _____ 1. _____
2. Occupation _____ 2. _____
3. Address _____ 3. _____
4. E-mail Address _____ 4. _____
5. In connection with what trade or business did you employ the injured person? 5. _____
6. Are you insured elsewhere against this risk? If so, give name of Company. 6. _____

PARTICULARS OF INJURED PERSON-

1. Name _____ Date of Birth _____
2. Occupation _____ Married or Single _____
3. Address _____ Number of children under 15 _____
4. Is (s)he related to you? If so, state relationship _____ Does (s)he reside with you? _____
5. (a) Is (s)he in you direct employ? 5. (a) _____
   (b) Is (s)he in your sole employ? (b) _____
   (c) Since what date? (c) _____
6. If in the service of a Sub-Contractor, give the name and address of the Sub-Contractor 6. _____

THE ACCIDENT

1. State the Date, Hour and Place of Occurrence 1. Date _____ Hour _____ Place _____
2. State when Injured Employee ceased work 2. Date Hour
3. Describe fully how the accident happened:- _____

4. State precisely the duties of the Injured Employee when accident occurred 4. _____
5. What was the general nature of the work going on? 5 _____
6. What machinery was in use in connection with the work? 6. _____
7. (a) Give date he injured person first reported the accident. 7. (a) _____
   (b) To whom was it reported? (b) _____
8. Did the accident occur during his/her working hours? 8. _____
9. Was (s)he sober? 9. _____
10. (a) Was (s)he guilty of any misconduct or disobedience to orders? 10. (a) _____
    (b) If so, give particulars (b) _____
11. (a) Was the accident due to negligence upon the part of any person? 11. (a) _____
    (b) If so, give name, and state whether such person is in your direct employ. (b) _____
12. Names and address of any witnesses of the accident. 12. _____

THE INJURY

1. State very fully the nature and extent of the injury

   N.B. - If to a limb, state whether right or left.

1. _____

   _____

2. (a) Is the Injured Employee able to attend to any portion of his/her work?

   (b) If so, what is the value of his/her present service?

2. (a) _____

   (b) _____

3. What is the likely duration of incapacity?

3. _____

4. Where was (s)he taken after the accident?

4. _____

5. Where is (s)he now?

5. _____

6. Name and address of Doctor in attendance

6. _____

GENERAL INFORMATION-

Give all such details respecting the Accident and the Injured Employee as would be of assistance to the Company.

_____

_____

_____

_____

_____

What are the wages of the employee?

Weekly _____

Monthly _____

I/We the undersigned Insured hereby declare that the above statements and facts are true and that I/We have not withheld from the Company any information within my/our knowledge connected with the claim.

Date _____ Signature of Insured _____

Please enclose medical certificate, if available

N.B. - The Company does not admit liability by the issue of this Form.