Claim No. .....

The Insurance Company of the West Indies Limited

EMPLOYERS NOTICE OF INJURY FORM

This Form should be returned, fully completed by Employer, to 2 St. Lucia Avenue, Kingston 5, Tel: 92-69182-5, 92-69040-5

within 48 hours after the accident

ALL QUESTIONS MUST BE ANSWERED IN DETAIL

Name of Employer _____

Address _____

Occupation _____ Policy No. _____

1. Name of Injured Person: _____ Age _____
2. Address _____ Occupation _____
3. Date Employment commenced _____
4. Was the injured Person in your direct employ? If not give name and address of employer. _____
5. State (1) Time (2) Date (3) Place of Accident. (1) _____ (2) _____ (3) _____
6. Have you received a formal notice of the accident. If so (1) when (2) in what form: _____ (1) _____ (2) _____
7. Describe briefly how accident happened (see below): _____
8. If machinery was involved (1) was a guard provided (2) was it being used? (1) _____ (2) _____
9. Was it during the proper performance of his /her work? _____
10. Who witnessed the accident? _____
11. On what date did the injured person cease work? _____
12. State shortly the nature of the injuries received and whether the injuried person is able to perform any part of his/her duties. _____
13. Probable period of disablement: _____
14. Is the workman paid daily or otherwise? When was he last paid? _____
15. Where is the injured person receiving medical treatment? State if admitted to hospital. _____
16. Has the injured person (1) resumed work, if so state date (2) been certified fit by doctor, if so date. (1) _____ (2) _____

IF ACCIDENT WAS CAUSED BY (1) WORKMAN'S DISOBEDIENCE OR MISCONDUCT (2).. WORKMAN UNDER THE THE INFLUENCE OF DRINK OR DRUGS OR BREAKING ANY RULE OR ORDER (3) ANY DEFECT IN EMPLOYERS BUILDING OR EQUIPMENT (4) THE FAULT OR NEGLIGENCE OF ANY OTHER PERSON (5) PRE-EXISTING SICKNESS OR DISEASE OF WORKMAN – GIVE FULL PARTICULARS IN SPACE PROVIDED OVERLEAF.

I/We certify that the above statement and information supplied overleaf is true and complete to the best of my/our knowledge and belief.

Employer's Signature _____ Date _____

It is necessary that the fullest information should be given in order to avoid delay and the trouble to policy holders of subsequent correspondence.

THE INSURERS DO NOT ADMIT LIABILITY BY THE ISSUE OF THIS FORM

PLEASE TURN OVER